

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00161

Reg. Dist. No. 38

1. PLACE OF DEATH:

County BaltimoreCity or town Baynesville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 yearsHospital, institution, or street address where death occurred:
1646 Mussula Rd.

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife Wm. G. Alexander7. Birth date of deceased (mo., day, yr.) Oct. 20th, 19248. AGE: Years Months Days If less than one day
23 2 12 hrs. min.9. Birthplace Ohio
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Robert R. Ross13. Birthplace Ohio14. Maiden name Mary Hegfield15. Birthplace Ohio16. Informant Mr. Wm. G. AlexanderAddress 1646 Mussula Road17. burial Date thereof Jan. 5, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Greenland MemorialLocation Balto. Md.18. Funeral director Lawson Funeral HomeAddress 7401 Belair Road19. 1/3 48 A. W. Bacon
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Baynesville
(If outside city or town limits, write RURAL and give nearest town)Street No. 1646 Mussula Rd.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 19 48 at 3 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from home home
and that I last saw him alive on Jan. 2, 1948Immediate cause of death Gas poisoning, SuicideDue to mental depression, anxiety with frequent crying and childbearing

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:
Accident, suicide or homicide suicide Date of Jan. 2, 1948Where did injury occur? Baynesville Baltimore Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury Gas poisoning - Suicide Injured at work? No.23. SIGNATURE William G. Alexander M.D.Address Towson Md. Date signed 1/3/48

11.04.48

RECEIVED

JAN 6 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00162

Reg. Dist. No. 43

1. PLACE OF DEATH

County Balto.City or town Roxbury, Balto Co
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Rt 2, Old Phila Rd + Mohr Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Balto County BaltoCity or town Balto
(If outside city or town limits, write RURAL and give nearest town)Street No. 3615-17 Chestnut Ave
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Jane E. Allen

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Morgan A. Allen7. Birth date of deceased (mo., day, yr.) March 24 / 18738. AGE: Years 74 Months 9 Days 10 If less than one day
hrs. min.9. Birthplace Columbia, Pa
(To give county and state)10. Usual occupation Housewife11. Industry or business at home12. Name Henry S. Tracey13. Birthplace Maryland14. Maiden name Lidia G. Bates15. Birthplace Maryland16. Informant Roy AllenAddress Old Phila Rd + Mohr Lane17. Bureau Date thereof Jan 6 / 47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Wards ChapelLocation Balto Co, Md18. Funeral director Chenoweth + SonovanAddress 3615-17 Chestnut Ave19. 1-5 48 Registrar Dec 11 / 48

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 19 48 at 12:05 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 48 to 19 48and that I last saw him alive on 19 48Immediate cause of death Cerebral hemorrhageDURATION 16 yrs.Due to Hemiplegia + paralysisDue to left side

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

13. SIGNATURE Wm. D. McLearnAddress Balto Co, MarylandDate signed 1/4/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. ✓

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Arbutus
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? one yearHospital, institution, or street address where death occurred:
1005 Beechfield Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Arbutus
(If outside city or town limits, write RURAL and give nearest town)Street No. 1005 Beechfield Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Elizabeth Anderson

3.(b) Social Security Number

4. Sex

Female

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Esau Anderson

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) May 24, 1854.

8. AGE:

Years

93

Months

7

Days

18

If less than one day

..... hrs.

..... min.

9. Birthplace

Bivalve, Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

Joshua Jackson

13. Birthplace

Md.

MOTHER

14. Maiden name

Unknown

15. Birthplace

Md.

16. Informant

Maxwell J. Anderson

Address

1005 Beechfield Ave.

17.

BurialDate thereof Jan. 15/48
(month) (day) (year)

Cemetery or crematory

Tyaskin M.E. Church Cemetery

Location

Tyaskin, Md.

18. Funeral director

Harry H. Ruffe

Address

4101 Edmondson Ave.

19.

1/14/48
(Date rec'd by registrar)A. W. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12/48 19..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1 - 1947 to June 12 1948
and that I last saw her alive on Jan 12 - 1948

Immediate cause of death

bedriddenSenility

DURATION

Due to

Myocarditis / Arteriosclerosis

Due to

Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert E. Guter

M. D. or other

Address

2151-WilliamsonDate signed 1/13/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

548

00164

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

County Baltimore
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
613 Overbrook Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Baltimore
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 613 Overbrook Rd
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Mildred E. Anderson

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Lester W. Anderson

7. Birth date of deceased (mo., day, yr.) Sept 21, 1911 6. (c) If alive, give age _____ years

8. AGE: Years 36 Months 3 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Methuen, Mass
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Frank S. Valley

13. Birthplace Adams, Mass

14. Maiden name Ella Conroy

15. Birthplace Adams, Mass

16. Informant Lester W. Anderson

Address 613 Overbrook Rd

17. Date of death Jan 13, 1948
(Burial, cremation, or removal, which?) Date thereof _____ (month) (day) (year)

Cemetery or crematory Mount Vernon

Location Baltimore, Md

18. Funeral director William E. Jones

Address 1219 E. Bond St

19. Date rec'd by Registrar 1/14/48 Registrar A. W. Feltus

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13, 1948 at 3:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1, 1946, to 1/12/48 and that I last saw him alive on 1/12/48

Immediate cause of death Cerebral Hemorrhage DURATION 5 Days

Due to Carcinoma of The Brain 3 1/2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank S. Valley MD M. D. or other

Address 7301 York Rd Date signed 1/13/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00165

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Approximately 40 Minutes
Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
How long in hospital or institution? Approximately 40 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County _____
City or town Essex (21)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Hyde Park
(If rural, give LOCATION)
2.(a) If veteran, name war VV-I

3. (a) FULL NAME

JOHN T. ANDREWS

3. (b) Social Security Number

216-18-3477

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Anna Andrews

6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 5-12-94

8. AGE: Years 53 Months 7 Days 26 If less than one day _____ hrs. _____ min.

8. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business _____

12. Name John Thomas Andrews

13. Birthplace Maryland

14. Maiden name Bertha Betkey (Betkey)

15. Birthplace Germany

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial Date thereof Jan. 12/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore Nat. Cem.

Location Baltimore

18. Funeral director Phil's Herwig Sons

Address 2024 Orleans St.

19. 1/12 19 48 W. Hedrick

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 19 48 10:10 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 8, 19 48 to January 8, 19 48 and that I last saw him alive on January 8, 1948

Immediate cause of death Hemorrhage DURATION Sudden

Due to Esophageal varices 1 yr. plus

Due to Portal Cirrhosis 1 yr. plus

Other conditions Cholelithiasis Unknown

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results Substantiated Above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William E. Ragdale Jr. M. D. or other

Address V.A.H. FORT HOWARD, MD. Date signed 1-9-48

MARGIN RESERVED FOR BINDING

VS A15 9:45:15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Reg. Diat. No. 40

1. PLACE OF DEATH:

County Walden
City or town Wash. Cliff near Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give reactivity of mother)

State Maryland County Baltimore
City or town Hotel Elff, near Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Sister Mary Boniface Balzer

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

B.(b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1863

8. AGE:	Years	Months	Days	If less than one day
	8 4	3	24 hrs. min.

B. Birthplace.....Rochester N.Y......
(Town, county, and state)

10. Usual occupation.....*Teacher*

11. Industry or business

FATHER 12. Name *August Balzer*
13. Birthplace *Alsace Lorraine*

MOTHER
14. Maiden name..... *Adelaide Michel*
15. Birthplace..... *Germany*

16. Informant En. Mary Clara
Address Notch cliff, Md

17. Interment Date thereof Jan 29 / 78
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory North Hollywood
Location Greenwood

1B. Funeral director Rev. M. J. Smith
Address 811 N Wolfe St

19 11/29 19 88 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1948 at 3.15 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
September 18, 45 to Jan 27 1948
and that I last saw her alive on Jan 24 1948

Immediate cause of death.....	DURATION
Myocardial infarction.....	1 yr.....

Due 10.....

Due to.....

Other conditions: Arterio Sclerosis ⁴⁴⁴ Hypertension

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury	Injured at work?
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23. SIGNATURE _____

Address 1000 1st St Date signed 10/1/74

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 3 1948
BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Baltimore
 City or town Reisterstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:
Cockeys Mill Road Reisterstown
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Reisterstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Cockeys Mill Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war No

3. (a) FULL NAME

James Franklin Barnes

3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced W

6. (b) Name of husband or wife Jennie Sprinkle Barnes

7. Birth date of deceased (mo., day, yr.) August 27 1857 8. (c) If alive, give age - years

8. AGE: Years 90 Months 4 Days 15 If less than one day - hrs. - min.

9. Birthplace Reisterstown Balto Co Md
 (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

12. Name Joshua Barnes13. Birthplace Carroll County14. Maiden name Clarcy Daniels15. Birthplace Carroll County16. Informant Mrs Cora BensonAddress Cockeys Mill Rd Reisterstown

17. Burial Date thereof Jan 14 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bethel CemeteryLocation Carrollton Md18. Funeral director Wm Berryman & SonsAddress Reisterstown Md

19. 1-12- 19 47 Mary B. E. Line
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-12- 19 48 at - M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19
 and that I last saw him/her alive on 1-10-48 19

Immediate cause of death

Myocardial infarction
Chronic - decompensated
hypertension

Due to

arteriosclerosis - general
prostatic hypertrophy

Due to

prostatic hypertrophy
 (Include pregnancy within 3 months of death)

Other condition

prostatic hypertrophy
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op. -

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -

23. SIGNATURE James E. Saffel
Reisterstown, Md. M. D. or other

Address Reisterstown, Md. Date signed 1/12/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00168

40

1. PLACE OF DEATH: Baltimore County
County..... 1204 62nd. Street

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Md. County..... Baltimore

City or town..... Baltimore - rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1204 - 62nd. Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

JULIA BATTEE

3. (b) Social Security Number
none

4. Sex..... F 5. Color or race..... W 6.(a) Single, married, widowed, or divorced..... Widow

6.(b) Name of husband or wife..... George Perry Battee

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) March 1, 1871

8. AGE: Years..... 76 Months..... 10 Days..... 15 If less than one day..... hrs. min.

9. Birthplace..... Baltimore, Md.
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Bernardt. Kimmerle

13. Birthplace..... Germany

14. Maiden name..... Catherine Sauer

15. Birthplace..... Germany

16. Informant..... Mr. Carl J. Battee

Address..... 1204 - 62nd. Street

17. Burial..... Date thereof..... 1/20/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... First Evangelical Cem.

Location..... Baltimore, Md.

18. Funeral director..... HENRY SANDER & SONS, INC.

Address..... NORTH AVE. & BROADWAY

19. 1/18 1948 R. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan. 16, 1948 19..... at 12.55 ^A _M

21. I CERTIFY that death occurred on the date above stated; that patient deceased from

Jan. 6 1939 to Jan. 16 1948
and that I last saw her alive on Jan. 15 1948

Immediate cause of death..... Acute Cardiac failure DURATION..... 4 days

Due to..... Arteriosclerotic Heart Disease. Egm.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Israel Rosen M.D.

Address..... 2413 E Monument St. Date signed..... 1/17/48

MARGIN RESERVED FOR BINDING

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VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00169

Reg. Dist. No. 31

1. PLACE OF DEATH:

County Baltimore
City or town Harrisonville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Harrisonville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Deer Park Road
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

George McCallan Batter

3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Widower
6. (b) Name of husband or wife Sara M. Batter
7. Birth date of deceased (mo., day, yr.) Oct. 9 - 1862 8. (c) If alive, give age Deceased years
8. AGE: Years 85 Months 3 Days 17 If less than one day hrs. min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Lewis Batter
13. Birthplace Carroll Co. Md.

14. Maiden name Maggie Crabster
15. Birthplace Carroll Co. Md.

16. Informant Lewis Morton Batter
Address 3522 Rolling Rd. Rockdale, Md.

17. Burial (burial, cremation, or removal. Which?) Burial Date thereof January 24, 1948
(month) (day) (year)
Cemetery or crematory Holy Family Cemetery
Location Harrisonville, Md.

18. Funeral director Frank H. Newell
Address Pikesville, Md.

19. 1/21/48 Frank E. Martini
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 19 48 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Jan. 21, 1948
and that I last saw him alive on Jan. 20 19 48

Immediate cause of death Cardiovascular Disease DURATION 3

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank E. Martini M. D. or other

Address Pandalltown, Md. Date signed 1/21/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
FEB 2 1948
FEB 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00170

Reg. Dist. No.

38

1. PLACE OF DEATH:

County Beth Md
 City or town Parkville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2608 Wendover Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore
 City or town Parkville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2608 Wendover Road
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mary A. Bell

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced widowed

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan. 16. 1888 6. (c) If alive, give age _____ years

8. AGE: Years 68 Months _____ Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore - Md
 (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

12. Name Thomas McDonald13. Birthplace Baltimore - Md14. Maiden name Elizabeth Blakeney15. Birthplace Balt - Md16. Informant Mrs. Lillian WillisAddress 2608 Wendover Road17. Burial Date thereof 1/19/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore CemeteryLocation North & Nelson Ave18. Funeral director Howard W. Bright & Co.Address 6009 Harford Road19. 1-20 19 48 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 19 48 at 10:45 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 45 to Jan 19 48and that I last saw him alive on Jan 14 19 48Immediate cause of death Cardiac failure

DURATION

Due to Hypertensive cardio-vascular disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thomas J. Brennan, M.D.Address 5217 Harford Rd Date signed 1-19-48

M. D. or other

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Live correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00171

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltoCity or town Essex
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

13 Warren Rd

How long in hospital or institution?

3. (a) FULL NAME

Frederick W. Berghoff

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

8. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Heather (Ziegler) Berghoff

7. Birth date of deceased (mo., day, yr.)

June 20 - 18768. (c) If alive, give age 65 years

8. AGE:

Years 71 Months 6 Days 19 If less than one day

9. Birthplace

md
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

none

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Mr. Elias Berghoff

Address

13 Warren Rd

17. (Burial, cremation, or removal, Which?)

Burial

Cemetery or crematory

St. Bernard's

18. Funeral director

John J. Connolly

Address

418 Eastern Ave.19. 1-12-48 19

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

md.

County

Balto.

City or town

Essex
(If outside city or town limits, write RURAL and give nearest town)

Street No.

13 Warren Rd.
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 1948 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 5, 1947 to 9 Jan. 1948and that I last saw him alive on 9 Jan. 1948

Immediate cause of death

Hypostatic pneumoniaMalnutrition

Due to

Apoplexy

Due to

Cerebral arteriosclerosis& hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Maxwell H. D.
417 Eastern Ave. Date signed 1-12-48

M. D. or other

RECEIVED
JAN 16 1948
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00172

Reg. Dist. No. 33

1. PLACE OF DEATH

County Baltimore
City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County Balto.
City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)

Street No. Berry Hill
(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3. (a) FULL NAME

Frank Nelson Bolton

3. (b) Social Security Number

4. Sex

m

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Mary H. Thompson

7. Birth date of deceased (mo., day, yr.)

Jan 28 1893

6. (c) If alive, give age

52 years

8. AGE:

Years

Months

Days

If less than one day

53

11

14

hrs.

min.

9. Birthplace

Balto. Ind.
(Town, county and state)

10. Usual occupation

Banker

11. Industry or business

FATHER
MOTHER

12. Name

Frank C. Bolton

13. Birthplace

Cecil Co Ind

14. Maiden name

Annny Alfreda Johnson

15. Birthplace

Balto Ind

16. Informant

Mrs. F. Nelson Bolton

Address

Owings Mills Ind

17.

Bureau

Date thereof

Jan 13 1948

(Burial, cremation, or removal, Which?)

Cemetery or crematory

St Thomas

Location

Garrison Forest Ind

18. Funeral director

Henry W. Jenkins - Mo

Address

McCulloch Orchard St

19.

Jan 12 1948

F. A. W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 11 1948 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1930 to Jan 11 1948

and that I last saw him alive on Jan 11 1948

Immediate cause of death

Multiple Sclerosis

Hypertension

arterio-sclerosis

Chr. nephritis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Palmer R. Williams

M. D. or other

Address Pikesville Md Date signed 1/11/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The current age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of
year of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00173

CERTIFICATE OF DEATH

Reg. Dist. No. 57

FILE No. G 114 FEB 4 - 1948

1. PLACE OF DEATH: Baltimore
County.....
City or town Rural Sparks
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 68 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Rural Sparks
(If outside city or town limits, write RURAL and give nearest town)
Street No. Quaker Bottom Road
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME

Oliver McKinley Britton

3.(b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Harriet Irely Britton (deceased)

7. Birth date of deceased (mo., day, yr.) May 1, 1880 1879

8. AGE: Year 68 Month 9 Days 24 If less than one day hrs. min.

9. Birthplace Baltimore County, Maryland
(Town, county, and state)

10. Usual occupation laborer (retired)

11. Industry or business

12. Name John Britton

13. Birthplace Baltimore County, Maryland

14. Maiden name Martha Johnson

15. Birthplace Baltimore County, Maryland

16. Informant Henry Britton

Address Sparks, Maryland

17. Burial Date thereof Jan 26, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Stevenson

Location Sparks, Md.

18. Funeral director Stanton M. Bevels

Address Sparks, Md.

Jan. 25, 1948 Wilmer C. Ensor

19. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 January 1948 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1947 to January 1948
and that I last saw him alive on 19 January 1948

Immediate cause of death Cerebral vascular accident DURATION 2 wks.

Due to Hypertension 1 yr.

Due to Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE Walter T. Kees, M.D. M. D. or other

Address Cockeysville, Maryland Date signed 1-24-48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 27 1948

BUREAU - 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Essex
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

5-6 Glenwood Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltoCity or town Essex # 21
(If outside city or town limits, write RURAL and give nearest town)Street No. 5-6 Glenwood Rd
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (a) FULL NAME

David Lee Brown

3. (b) Social Security Number

209-05-56064. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorcedMarried6. (b) Name of husband or wife Nancy

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Dec. 25-18898. AGE: Years 58 Months _____ Days _____ If less than one day

..... hrs. min.

9. Birthplace Penn.

(Town, county, and state)

10. Usual occupation Miner

11. Industry or business

12. Name David Brown13. Birthplace Penn14. Maiden name Adeline Moss15. Birthplace Penn16. Informant Nancy BrownAddress 5-6 Glenwood Rd17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 1-3-48

(month) (day) (year)

Cemetery or crematory Oak GroveLocation Balto Co18. Funeral director J. BrundnickAddress 1967 Eastern Ave Rd19. 1/2 48 ACW Hedrick

(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1948, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1946, to Jan 1 1948and that I last saw him alive on December 31 1947Immediate cause of death Cardiac FailureDURATION 4 yearsDue to Generalized arteriosclerosis

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

13. SIGNATURE Irving R. Beck MDAddress 30 Chandelle Rd Balto MDDate signed Jan 21 1948

MARGIN RESERVED FOR BINDING

VS A15

9-43-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0017544

1. PLACE OF DEATH

County Balt.City or town Sparrow Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

721 East E. St.

How long in hospital or institution?

20 yrs

3. (a) FULL NAME

John Morgan Brown.

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Sarah.

7. Birth date of

deceased (mo., day, yr.)

Jan 21/1860

8. AGE:

Years

88

Months

11

Days

24

If less than one day

hrs.

min.

6. (c) If alive, give age

years

10. Usual occupation

Retired

11. Industry or business

Painter

12. Name

Brown

13. Birthplace

Pa.

14. Maiden name

Eleanor Morgan

15. Birthplace

Pa.

16. Informant

Mrs. Jane Brown

Address

721 East E. St. S. P. Md

17. (Burial, cremation, or removal)

Buried

Date thereof

Jan. 17-48

(month) (day) (year)

Cemetery or crematory

Woodlawn

Location

Swynn Oak an

18. Funeral director

John. A. Moran

Address

3000 E. Balt. H.

19. (Date rec'd by registrar)

1-16-48

Registrar

W. J. McLean

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State

Md.

County

Balt.

City or town

Sparrow Pt.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

721

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 14 1948

at

9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 4 1948

to

Jan 14 1948

and that I last saw him

alive on

Jan 14 1948

Immediate cause of death

Coronary accident

Due to

Arteriosclerosis

Other conditions

None

(Include pregnancy within 3 months of death)

Major findings of operations

None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

Coronary accident

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Jan 14 1948

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Signature

W. J. McLean M.D.

Address

Balt. Co. Maryland

Date signed

Jan 14 1948

DURATION

14 days

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 00176
 30
 Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Catonsville 28, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 4 yrs. 4 mos. 26 das.
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution?..... 4 yrs. 4 mos. 26 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Mt. Rainier, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2. (a) If veteran, name war..... ✓

3. (a) FULL NAME

Elsa Helena Brudin

3. (b) Social Security Number

4. Sex..... F 69
 5. Color or race..... white
 6. (a) Single, married, widowed, or divorced..... Married
 6. (b) Name of husband or wife..... John F. Brudin
 6. (c) If alive, give age..... 75 years
 7. Birth date of deceased (mo., day, yr.)..... May 1st, 1878
 8. AGE: Years..... 69 Months..... 8 Days..... 27 If less than one day..... hrs. min.

9. Birthplace..... Sweden
 (Town, county, and state)
 10. Usual occupation..... Housewife
 11. Industry or business..... Domestic
 12. Name..... John Graff
 13. Birthplace..... Sweden
 14. Maiden name..... Sophia Lind
 15. Birthplace..... Sweden

16. Informant..... Hospital Records
 Address..... Catonsville 28, Maryland
 17. Removal
 (Burial, cremation, or removal, Which?) Date thereof..... Jan 28 1948
 (month) (day) (year)
 Cemetery or crematory..... Hyattsville, Md.
 Location..... as above
 18. Funeral director..... F. Hensch's Sons
 Address..... Hyattsville, Md.
 19. Jan. 28 1948
 (Date rec'd by registrar) V E Harry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 28 1948 at 5:50 a M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....
 and that I last saw him..... alive on..... 19.....
 Immediate cause of death.....
Arteriosclerotic Heart Disease
Coronary Sclerosis
Generalized Arteriosclerosis
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 8 months of death)

DURATION

Major findings of operations..... Date of op.....
 As above
 Antopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?
 23. SIGNATURE..... Geo M Kieffer Dept Head
 M. D. or other
 Address..... 1010 Leeds on Date signed..... 1-28-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00177

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
City or town Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs., 7 mos., 23 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. T. B. Sanatorium
How long in hospital or institution 9 yrs., 7 mos., 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2849 W. Mulberry Street
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Henry W. Bruggeman

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife Mrs. Viola Bruggeman

7. Birth date of deceased (mo., day, yr.) August 29, 1905 6. (c) If alive, give age _____ years

8. AGE: Years 42 Months 4 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Chauffeur

11. Industry or business _____

FATHER 12. Name Fred Bruggeman

13. Birthplace Germany

MOTHER 14. Maiden name Lena Wehrenberg

15. Birthplace Germany

16. Informant Henry W. Bruggeman

Address 2849 W. Mulberry St., Balto., Md.

17. Burial Date thereof Jan. 30, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Paul Cemetery

Location Violetsville, Md.

18. Funeral director Teufel & Son

Address 5311 Edmondson Ave., Balto., Md.

19. Jan. 27, 1948 Earl T. Webster
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1948 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4, 1938 to Jan. 27, 1948 and that I last saw him alive on January 27, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 10 yrs.

Due to Tubercle Bacilli

Due to _____

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op. _____

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Stewart S. Shaffer M.D. _____ M.D. or other

Address Mt. Wilson, Md. Date signed 1/27/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Opitz Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 613 Coleraine Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MARY CATHERINE BURNS

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife Edward J. Burns

7. Birth date of deceased (mo., day, yr.)

Dec. 8, 1861

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

86

1

0

hrs.

min.

9. Birthplace Covington, Va.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

Patrick Charles Winters

13. Birthplace

Ireland

MOTHER

14. Maiden name

Catherine Theresa McFarland

15. Birthplace

Philadelphia

16. Informant

Mrs. Benj. Nicoll

Address

613 Coleraine Rd.

17.

Burial

Date thereof

1/10/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

New Cathedral Cem.

Location

Baltimore, Md.

18. Funeral director

WM. J. TICKNER & SONS

Address

Balto., Md.

19.

January 9, 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8, 19 48 at 2:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 15, 1947 to Jan 8, 1948and that I last saw him alive on Jan 7, 19 48

Immediate cause of death

Coronary thrombosis 3 days

DURATION

Due to

Coronary Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James H. Towne

M. D. or other

Address Catonville Date signed 1-9-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00179
Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore

City or town Rosemont
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

4014 Baltimore Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Rosemont
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4014 Baltimore Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Susan M. Calvert

3.(b) Social Security Number

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife John G. Calvert

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 20, 1878

8. AGE:

Years

Months

Days

If less than one day

70

0

9

hrs.

min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John Deutsch

13. Birthplace Germany

14. Maiden name Susan Hinterlang

15. Birthplace Germany

16. Informant Dolores Taras

Address 4014 Baltimore Street, Rosemont

17. burial Date thereof 2/2/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Meadow Ridge

Location Howard County, Maryland

18. Funeral director Wm. Cook, Inc.

Address 1217 St. Paul Street

19. 1-31 19 48 A. H. Haderick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29, 1948 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/10 43 to 1/29 48
and that I last saw him alive on 1/29 48

Immediate cause of death Acute Cardiac Failure DURATION 1 da

Due to Hypertensive Cardiac

Due to Chronic Renal Disease 5 yr

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph H. Lawrence M.D. M. D. or other

Address 679 W. Washington Blvd. Date signed 1/30/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County... 315 Ingleside Ave

City or town... Catonsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County...

City or town... 315 Ingleside Ave., Catonsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. ---

(If rural, give LOCATION)

2.(a) If veteran, name war ---

3. (a) FULL NAME

HENRY K. CAMMANN

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife... Florence E.

8. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1863

8. AGE: Years Months Days If less than one day
84 5 3 hrs. min.8. Birthplace... Virginia, -- Henrica County
(Town, county, and state)

10. Usual occupation... Book Binder (Retired)

11. Industry or business... Selt

12. Name... Charles F. Cammann

13. Birthplace... Germany

14. Maiden name... Mary A. Ashton

15. Birthplace... Maryland

16. Informant... John S. Cammann

Address... 1362 Pentwood Rd.

17. Removal Date thereof 1/13/48

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... Meadow Farm Burial Plot

Location... Glen Allen, Va.

18. Funeral director... WM. J. TICKNER & SONS

Address... North & Pa. Aves., Balto., Md.

19. Jan 12 19 48 R. G. Hedrick

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 19 48, at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1, 19 47, to January 9, 19 48

and that I last saw him alive on January 8, 19 48

Immediate cause of death Myocardial

Due to Atherosclerosis of C.V. system

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Korman M. D. or other

Address Elm City, Md. Date signed 1/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00181

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Mount Wilson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs., 1 mo., 22 days
 Hospital, institution, or street address where death occurred: Mt. Wilson
Branch, Md. T. B. Sanatorium
 How long in hospital or institution? 2 yrs., 1 mo., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard Co.
 City or town Ellicott City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Garland Campbell

3. (b) Social Security Number

Unknown

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mr. Nelson Campbell
 7. Birth date of deceased (mo., day, yr.) Feb. 16, 1918
 6. (c) If alive, give age 34 years
 8. AGE: Years 29 Months 10 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Jacksonville, North Carolina
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Arthur
 13. Birthplace North Carolina
 MOTHER 14. Maiden name Mildred Marshall
 15. Birthplace North Carolina

16. Informant Mrs. Garland CampbellAddress Ellicott City, Howard Co., Md.17. Burial Date thereof Jan. 11, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak Grove CemeteryLocation Glen Wood, Howard Co., Maryland18. Funeral director Easton & SonsAddress Ellicott City, Md.19. Jan. 8, 1948 Earl T. Webster
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1948 at 10:15 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17, 1945 to Jan. 8, 1948and that I last saw her alive on January 8, 1948Immediate cause of death Pulmonary Tuberculosis DURATION 6 1/2 yrs.Due to Tubercle Bacilli

Due to _____

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE B. I. Siegel M.D. M. D. or other _____Address Mt. Wilson, Md. Date signed 1/8/48

RECEIVED
JAN 15 1948
NCR

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00182

Reg. Dist. No. 3/

1. PLACE OF DEATH:

County BaltoCity or town Randallstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 Month

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltoCity or town Randallstown
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Howard Williams Cassell

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife Unknown7. Birth date of deceased (mo., day, yr.) Feb. 20, 1867

6.(c) If alive, give age _____ years

8. AGE: Years 80 Months 10 Days 11 It less than one day _____ hrs. _____ min.9. Birthplace Baltimore City
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Thomas Dorsey Cassell13. Birthplace Baltimore City14. Maiden name Esther Louisa Burke15. Birthplace Baltimore City16. Informant W. Barry CasellAddress Brooklandville, Md.17. Burial Date hereof Jan. 3, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Druid RidgeLocation Balto. Co.18. Funeral director J. F. Eline & SonsAddress Reisterstown, Md.19. 1/1 19 48 Mr. E. Martin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 194821. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 15 1947 to Jan 1 1948and that I last saw him alive on Jan 1 1948Immediate cause of death Pneumomatomous nephritis

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

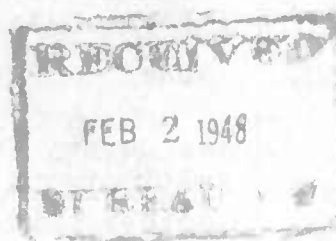
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Mr. E. Martin M. D. or otherAddress Randallstown Date signed 1/1/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00183

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Mount Wilson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr., 11 mos., 22 days
 Hospital, institution, or street address where death occurred: Mt. Wilson
Branch, Md. T. B. Sanatorium
 How long in hospital or institution? 1 yr., 11 mos., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3101 St. Paul St., Balto., Md.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

John S. Cassell

3. (b) Social Security Number

218-10-6698

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mrs. A. Louise Cassell
 7. Birth date of deceased (mo., day, yr.) July 30, 1881 8. (c) If alive, give age 64 years
 8. AGE: Years 66 Months 5 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation Construction Supt.
 11. Industry or business _____

MOTHER FATHER
 12. Name Jacob H. Cassell
 13. Birthplace Baltimore, Maryland
 14. Maiden name Josephine Anderson
 15. Birthplace Baltimore, Maryland

16. Informant John S. Cassell
 Address 3101 St. Paul St., Balto., Md.
 17. Burial Date thereof Jan. 24, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Lorraine Cemetery
 Location 6 E. Franklin St., Balto., Md.

18. Funeral director Wm. J. Tickner & Son
 Address Pa. & North Aves., Balto., Md.

19. Jan. 22, 1948 Earl Z. Webster
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1948 8:20 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31, 1946 to Jan. 22, 1948
 and that I last saw him alive on January 22, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 2½ yrs.

Due to Tubercle Bacilli

Due to _____

Other conditions Myocardiac Insufficiency

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Stewart S. Shaffer M.D. M. D. or other _____

Address Mt. Wilson, Md. Date signed 1/22/48

RECEIVED
JAN 27 1948
BUREAU OF POSTS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00184

43

1. PLACE OF DEATH:

County Balto. OverleaCity or town 6905 Linden Ave
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County BaltoCity or town 1
(If outside city or town limits, write RURAL and give nearest town)Street No. 6905 Linden Ave
(If rural, give LOCATION)

(2) If veteran, name war

3. (a) FULL NAME

Thomas J. Charvat

3. (b) Social Security Number

214-26-8596

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Anna M.

7. Birth date of

deceased (mo., day, yr.)

June 5 18806. (c) If alive, give age 67 years

8. AGE:

Years

Months

Days

If less than one day

67725hrs.min.

9. Birthplace

Balto

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Joseph Charvat

13. Birthplace

Czechoslovakia

MOTHER

14. Maiden name

Mary

15. Birthplace

Czechoslovakia

16. Informant

Anna M. Charvat

Address

6905 Linden Ave

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Burial2 3 48

Cemetery or crematory

Holy Redeemer

Location

4300 Belair Rd.

18. Funeral director

Dippel Bros.

Address

7110 Belair Rd

19.

(Date rec'd by registrar)

February 2, 1948R. W. Helms

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1948, at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1948 to January 31, 1948and that I last saw him alive on January 31, 1948

Immediate cause of death

Coronary Heart Failure

DURATION

Due to

Cardio - Vascular Hypertensive

Due to

Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Michael J. Dausch M.D.

M. D. or other

Address

1111 Overlea DrDate signed 1/31/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 00185 43
Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Overlea
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

100 W. Overlea Ave.

How long in hospital or institution?

3. (a) FULL NAME

EMMA M. CHESNEY

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Robert J. Chesney

7. Birth date of

deceased (mo., day, yr.)

November 12th, 1874

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

73125

hrs.

min.

9. Birthplace Balto., Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Bullinger13. Birthplace N.J.MOTHER 14. Maiden name Florence Burgan15. Birthplace Balto. Co., Md.16. Informant Mr. Robert J. ChesneyAddress 100 W. Overlea Ave.17. burial Date thereof Jan. 10, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lorraine ParkLocation Balto., Md.18. Funeral director Pasich Funeral HomeAddress 7401 Belair Road19. Jan. 8 19 47 Ans. A. I. Rufenstein
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Overlea
(If outside city or town limits, write RURAL and give nearest town)Street No. 100 W. Overlea Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7th, 1948 at 12:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1st 1947 to Jan 7 1948
and that I last saw him alive on Jan 7th 1948

Immediate cause of death

DURATION

myocardial infarction
Due to Cerebral Hemorrhage 3 months
Due to Arterio Sclerosis 2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. E. G. G. G. G. G. M. D. or otherAddress 100 W. Overlea Ave. Date signed 1/8/48



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. *00180*

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address *Balto Co*
 (c) Hospital or institution: *Gas and Electric Co. property--Turner Sta.*
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Balto Co*
 (c) City or town *Turner Station*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *107 Polaski Street*
 (If rural give location)
 (e) Citizen of foreign country? *(Yes or No)*
 If yes, name country

3 (a) FULL NAME

BERNARD

Clapp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex *Male* 5. Color or race *Colored* 6 (a) Single, married, widowed, or divorced *Single*

6 (b) Name of husband or wife *none*
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *8-15-26*

8. AGE: Years *21* Months *4* Days *18* If less than one day *hr.* min.

9. Birthplace *Turners Sta. Balto. Co., Md.*
 (Town, county, and state)

10. Usual Occupation *Unemployed*

11. Industry or business

12. Name *Claude Clapp*

13. Birthplace *N. C.*

14. Maiden Name *Willie Ann Hood*

15. Birthplace *Virginia*

16 (a) Informant *Edward Clapp*

(b) Address *539 So. Paca St.*

17 (a) *Burial* (b) Date thereof *1-6-48*
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Balto. national*

Location *Fredrick Ave. Balto. Md.*

18 (a) Funeral director *Charles R. Law*

(b) Address *802 Madison Ave.*

19 (a) *Jan 5 - 1948* (b) *A. W. Hedrick*
 (Date rec'd by registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH *January 2* 19 *48* at *8 A M*

21. I certify that I took charge of the remains described above, held an *Autopsy* thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to *His* death on the day stated above, and death in my opinion resulted from: *natural causes* ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH *acute alcoholism*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury *at* M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury *Car*

23. Signature *Carl Rye* M.D.

Date signed *1-2-48* Medical Examiner

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00187.

38

Reg. Diat. No.

1. PLACE OF DEATH:
County.....*Baltimore*
City or town.....*Towson*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....*25 years*
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....*MD* County.....*Baltimore*
City or town.....*Towson*
(If outside city or town limits, write RURAL and give nearest town)
Street No.....*7 May Ave.*
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME.....*Florence E. Clark*
3. (b) Social Security Number.....

4. Sex.....*Female*
5. Color or race.....*White*
6. (a) Single, married, widowed, or divorced.....*Widow*
6. (b) Name of husband or wife.....*Preston Clark*
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.).....*July 9 1888*
8. AGE: Year.....*59* Months.....*6* Days.....*-* If less than one day..... hrs. min.

9. Birthplace.....*Federal Hill Harford co. Md.*
(Town, county, and state)

10. Usual occupation.....*Housewife*

11. Industry or business.....

12. Name.....*George E. Thomas*

13. Birthplace.....*Not Known*

14. Maiden name.....*Margaret Ann Jones*

15. Birthplace.....*Rocke Md.*

16. Informant.....*Mr. Clifton Lewis*

Address.....*Rocke Md.*

17. Burial.....*St James* Date thereof.....*Jan 11-48*
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory.....*Federal Hill Harford co. Md.*

Location.....*Marion's Park*

18. Funeral director.....*Sanctusville Md.*

Address.....*Sanctusville Md.*

19. Jan 9 1948.....*W. H. Smith* Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Jan 9 1948* at.....*99* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....*Dec 1 1945* to.....*Jan 9 1948*

and that I last saw h..... alive on.....*Jan 9 1948*

Immediate cause of death.....*Cardio. Renal Disease*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*Louis A. Jones* M. D. or other

Address.....*2329 Queen St* Date signed.....*Jan 9 1948*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 4 1948

WEEA

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00197 32

1. PLACE OF DEATH:

County Baltimore
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 13 Walker ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

John R. Clark

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife Mary Ann Clark
 Date of death Dec 29 6.(c) If alive, give age 50 years
 Date of death (mo., day, yr.) Nov. 12 - 1864
 8. AGE: Years 83 Months 2 Days 17 If less than one day
 hrs. min.

Birthplace Woodmenburg, Maryland
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Contractor & Builder

12. Name Unk.

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant John Raymond Clark (Son)

Address 2319 Eutaw place, Balt. Md

17. Burial Date thereof Jan 31, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Druid Ridge

Location Pikesville, Maryland

18. Funeral director Frank H. Newell

Address Pikesville, Maryland

19. 1 - 30 - 1948 Dr. E. E. Nichol
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1948, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 29 1948 to Jan 29 1948
 and that I last saw him alive on Jan 29 1948.

Immediate cause of death Coronary Occlusion DURATION 15 min.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide

Where did injury occur? None
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. E. E. Nichol Med. Exam.
 M. D. or other

Address Registrar's town, Md. Date signed 1-29-48

NEWLAND STATE DEPARTMENT OF HEALTH

STATEMENT OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

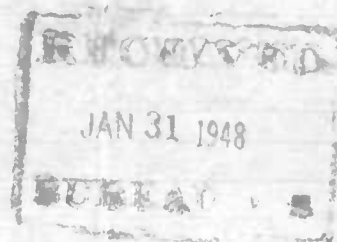
EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 138 00188 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.
 How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1531 McCulloh St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW-I

3. (a) FULL NAME

JAMES N. COLBERT

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race col. 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife deceased 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) August 18, 1889
 8. AGE: Years 58 Months 4 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Parole, Md.
 (Town, county, and state)
 10. Usual occupation unemployed
 11. Industry or business _____

FATHER 12. Name James Colbert
 13. Birthplace Maryland
 MOTHER 14. Maiden name Mary Diggs
 15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Maryland

17. Burial Date thereof Jan. 20, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baltimore Cemetery Fowlers Chapel
 Location West Gate, Md. Best Gate, Md.

18. Funeral director Hicks Funeral Home (Mrs. Chas. E. Hicks)
 Address Annapolis, Md. 45 Northwest Street

19. 1/20 48 Wm. J. French
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 19 48 4:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5 19 48 to January 17 19 48
 and that I last saw him in alive on January 17 19 48

Immediate cause of death _____ DURATION _____
Pulmonary Tuberculosis, bilateral 10 wks.
(all 5 lobes)

Due to _____

Due to _____

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Injured at work? _____

23. SIGNATURE JACK MORROW M. D. or otherAddress VAH FT. Howard, Md. Date signed 1-17-48

RECEIVED

JAN 21 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0018930

I. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

115 Stanford Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 115 Stanford Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Calara E. Coulehan

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Michael7. Birth date of deceased (mo., day, yr.) Sept 3 1864 6.(c) If alive, give age _____ years8. AGE: Years 83 Months 4 Days 1 If less than one day _____ hrs _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Stephen J Van Dell13. Birthplace MD14. Maiden name Elizabeth Charles15. Birthplace Tymap16. Informant Stephen J Van DellAddress 205 N. M. Pelling Road17. Funeral Date thereof 1-7-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CathedralLocation Baltimore18. Funeral director George A. ThibaultAddress Catonsville MD19. 1/8 19 48 A.W. Neelich
(Date rec'd by registrar) (year) (month) (day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 4 - 1948, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan - 9 - 1946, to Jan - 4 - 1948and that I last saw him alive on Jan - 2 - 1948Immediate cause of death Carcinoma Left Breast DURATION 2 yrs

Due to _____

Due to _____

Other conditions Red Streaks
metastases
(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results No Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of _____Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE S. Lloyd Johnson M. D. or other _____Address Catonsville MD Date signed 1/5/48

RECEIVED
JAN 8 1948
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? under
Hospital, institution, or street address where death occurred:
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Thurston R.D. 6
8122 Millendale Road
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

JAMES

John Taylor Coulter

3. (b) Social Security Number

215-09-4330

4. Sex M 5. Color W. 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Lillian May Coulter
7. Birth date of deceased (mo., day, yr.) July 18, 1980
8. AGE: Years 67 Months _____ Days _____ If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16, 1948 at 1:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____
and that I last saw him _____ 19____
Immediate cause of death Heart disease, chronic with coronary occlusion - sudden
DURATION 1/16/48

9. Birthplace Baltimore
(Town, county, and state)
10. Usual occupation Chauffeur
11. Industry or business Quaker Can Co
FATHER 12. Name Don't know
13. Birthplace Scotland
MOTHER 14. Maiden name Don't know
15. Birthplace Scotland

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

16. Informant Mrs Wm Jones
Address 3601 Southern Ave
17. Buried Date thereof Jan 18th, 1948
(Burial, cremation, or removal, which?) (month) (day) (year)
Cemetery or crematory Trinity Church
Location City
18. Funeral director Ullrich Funeral Home
Address 2008 Orleans St
19. 1/16/48 19 Arvid Ullrich
(Date rec'd by registrar) Registrar

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following: _____
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE Rollin G. Hudson M.D.
Address Towson, Md. Date signed 1/16/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 years

Hospital, institution, or street address where death occurred:

8215 Dundalk Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8215 Dundalk Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James Cowan

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife M. Grace Cowan7. Birth date of deceased (mo., day, yr.) 13 Feb. 1876

8. (c) If alive, give age

8. AGE: Years Months Days If less than one day

711016

.....hrs.min.

9. Birthplace Pikesville - Baltimore - Md.

(Town, county, and state)

10. Usual occupation Builder11. Industry or business Contracting12. Name John Cowan13. Birthplace Pikesville, Md14. Maiden name Catherine Himes15. Birthplace Baltimore Co., Md18. Informant Mrs. Wm CowanAddress Galveston, Texas17. Burial Date thereof Jan. 12 1948

(Burial, cremation, or removal, which) (month) (day) (year)

Cemetery or crematory St. John's CemeteryLocation Randallstown, Md.18. Funeral director Phillips AmericanAddress 4510 Liberty Heights Ave19. Jan 22 1948 A. W. Hedrick

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Jan. 1948, at 7:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

26 Aug. 1947, to 8 Jan. 1948and that I last saw him alive on 8 Jan. 1948

Immediate cause of death

PneumoniaDue to Cardiac decompensationHemiplegiaDue to Cerebral + coronaryarteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where)?

Means of injury

Injured at work?

23. SIGNATURE Wm CowanAddress 8 Liberty ParkwayDate signed 9 Jan. 48

M. D. or other

Dr. Bacon

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County ParkvilleCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7825 Oakleigh Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County ParkvilleCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 7825 Oakleigh Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mattie Gleaves Cox

3.(b) Social Security Number

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Joseph B. Cox

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

March 23, 1890

8. AGE:

Years

Months

Days

If less than one day

57916

_____hrs.

_____min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

FATHER
MOTHER

12. Name

Wm. Henry Allison

13. Birthplace

Va.

14. Maiden name

Alice Cecil

15. Birthplace

Va.

16. Informant

Mr. Joseph B. Cox

Address

7825 Oakleigh Road

17.

(Burial, cremation, or removal. Which?)

Date thereof

1-10-48

(month) (day) (year)

Cemetery or crematory

Moreland Memorial Park

Location

Baltimore, Md.

18. Funeral director

Leonard J. Ruck

Address

5305 Harford Road, 14

19.

(Date rec'd by registrar)

19 48A.M. Bacon

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8th, 1948, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1938 to Jan. 8, 1948and that I last saw her alive on Jan. 8, 1948

Immediate cause of death

DURATION

Coronary occlusion
(4th attack)4 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

A.M. Bacon, M.D.

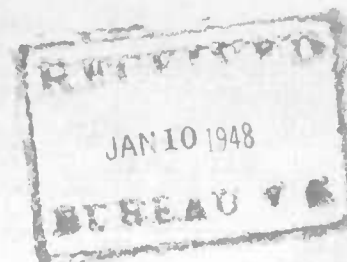
M. D. or other

Address 2810 Taylor Ave. Date signed 1/8/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

00193

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 251 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
How long in hospital or institution? 251 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County _____
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3535 Newland Road
(If rural, give LOCATION)
2.(a) If veteran, name war WW-I

3. (a) FULL NAME

CHARLES CRAMER

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) 11-15-87 6. (c) If alive, give age _____ years

8. AGE: Years 60 Months 1 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Houseman

11. Industry or business _____

FATHER 12. Name John Cramer
13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden name Katey
15. Birthplace Baltimore, Maryland

16. Informant Clinical Records, Vets. Adm. Hosp
Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 9, 48
(month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Baltimore, Maryland
Location _____

18. Funeral director Mamie Syfer
Address 1600 West North Avenue, Balto., Md.

19. Jan 6 19 48 A. H. Hedrick
(Time rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6, 19 48 at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 19 47, to January 6, 19 48
and that I last saw him alive on January 6, 19 48

Immediate cause of death Cerebral Thrombosis DURATION 6 Weeks

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results None performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel R. Usdin
DANIEL R. USDIN, M. D. M. D. or other

Address V.A.H. FORT HOWARD, MD Date signed 1-6-48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 001932

1. PLACE OF DEATH:

County..... Baltimore
City or town..... Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs., 6 mos., 27 days.
Hospital, institution, or street address where death occurred: Mt. Wilson
Branch, Md. T. B. Sanatorium
How long in hospital or institution? 3 yrs., 6 mos., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....
City or town..... Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 612 Wildwood Parkway
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Miss Margaret E. Creamer

3. (b) Social Security Number

705-05-2478

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
6. (b) Name of husband or wife.....		
7. Birth date of deceased (mo., day, yr.) <u>June 10, 1894</u>		
8. AGE: Years <u>53</u>	Months <u>6</u>	Days <u>30</u> If less than one day hrs. min.

9. Birthplace..... Baltimore, Maryland
(Town, county, and state)

10. Usual occupation..... Railroad Clerk

11. Industry or business

MOTHER FATHER	12. Name..... <u>George W. Creamer</u>
	13. Birthplace..... <u>Baltimore, Maryland</u>
	14. Maiden name..... <u>Lillian J. Mankin</u>
15. Birthplace..... <u>Baltimore, Maryland</u>	

16. Informant..... Margaret E. Creamer
Address..... 612 Wildwood Parkway, Balto., Md.

17. Burial..... Burial Date thereof..... 1-12-48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory..... Mt. Olive Cemetery

Location..... Baltimore, Maryland

18. Funeral director..... Edward Tolson

Address..... 2359 Washington Blvd., Balto., Md.

19. Jan. 9, 1948 Earl W. Webster
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 9, 1948 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 13, 1944 to Jan. 9, 1948
and that I last saw her alive on January 9, 1948

Immediate cause of death..... Pulmonary Tuberculosis DURATION 8 yrs.

Due to..... Tubercle Bacilli

Due to.....

Other conditions..... Tuberculous Enteritis 6 mos.

(Include pregnancy within 8 months of death)

Major findings of operations..... No operation
..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Stewart S. Shaffer m.d. M. D. or other

Address..... Mt. Wilson, Md. Date signed..... 1/9/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Woodbrook
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 3 1/2 years
 Hospital, institution, or street address where death occurred:
Mercy Villa
 How long in hospital or institution?..... 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County.....
 City or town..... Baltimore Greenway apt
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Charles - 34th St
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3.(b) Social Security Number

4. Sex..... F 5. Color or race..... W. 6.(a) Single, married, widowed, or divorced..... widowed
 6.(b) Name of husband or wife..... Richard Cromwell
 7. Birth date of deceased (mo., day, yr.)..... Oct 7 1862

8. AGE: Years..... 85 Months..... 2 Days..... 26 If less than one day..... hrs. min.

9. Birthplace..... Petersburg Va.
 (Town, county, and state)

10. Usual occupation..... House wife

11. Industry or business.....

FATHER 12. Name..... Wm. Johnson Michie
 13. Birthplace..... Va

MOTHER 14. Maiden name.....
 15. Birthplace.....

16. Informant..... Mr. Hubner Rice
 Address..... Ruxton Md

17. Burial..... Burial Date thereof..... Jan 5 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... New Cathedral
 Location..... Balt's. Md

18. Funeral director..... Henry W. Jenkins Smo
 Address..... M. Cullin & Richard St.

19. Date rec'd by registrar..... Jan 3 48 Registrar..... A. W. Gedrich

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 2 1948 at..... 5-1 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 1935 to..... Jan 2 1948
 and that I last saw him alive on..... January 2 1948

Immediate cause of death..... Cerebral Vascular accident DURATION..... 1 hour

Due to..... arteriosclerosis ?

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Francis W. Eluck M.D. M. D. or other.....Address..... 3406 St Paul St Date signed..... 1/2/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00196

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Balto
 City or town Catonoville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Belmdon
 Hospital, institution, or street address where death occurred:
Opitz Nursing Home
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County
 City or town Balto
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 422 Rosebank Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

George E. Cuttle

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife

Nellie P. Cuttle

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age years

Dec 24th 1876

8. AGE: Years Months Days If less than one day

71 0 21 hrs. min.

9. Birthplace (Town, county, and state)

Balto. Md.

10. Usual occupation

Retired

11. Industry or business

Salesman

12. Name

George Cuttle

13. Birthplace

England

14. Maiden name

Clara Towson

15. Birthplace

Balto. Md.

16. Informant

Alice P. Springer

Address

422 Rosebank Ave

17. (Burial, cremation, or removal, which?) Date thereof (month) (day) (year)

Burial 1/19/48
 Cemetery or crematory Balto.
 Location " Md.

18. Funeral director

William Cook Inc.

Address

1217 St. Paul st.

19. (Date rec'd by registrar)

1/19 48 A.W. Hedrick
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15th 1948 at 6 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

acute Cardiac failure

Due to

SenilityMalnutrition

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. M. K. Hedrick

M. D. or other

Address 1010 Lehigh Ave Date signed 1-17-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00198 30

1. PLACE OF DEATH:

County BaltimoreCity or town Calonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Calonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 408 Taylor Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Hester Ann Bailey

3. (b) Social Security Number

4. Sex Female 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife John R. Bailey7. Birth date of deceased (mo., day, yr.) Feb. 1, 1877 6. (c) If alive, give age 71 years8. AGE: Years 70 Months 11 Days 9 If less than one day hrs. min.9. Birthplace Howard Co. Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Thomas Baran13. Birthplace Howard Co. Md.14. Maiden name Hester Powell15. Birthplace Howard Co. Md.16. Informant Arla ScottAddress 408 Taylor Ave17. Burial Burial Date thereof Jan. 14, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. LawrenceLocation Bridge Md.18. Funeral director Mrs. Kate R. WilliamsAddress 322 N. Schroeder St.19. 1/14/48 A.W. Hedrick
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10th 1948 at 8:30 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct-12 1947 to Jan 10 1948 and that I last saw her alive on Jan 10 - 1948

Immediate cause of death

DURATION

Mitral Insufficiency
Due to Arteriosclerotic
Due to Heart Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C.F. Maloney

M. D. or other

Address Calonsville, Md Date signed 1/11/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00199

Reg. Diat. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Edmondson & Rosewood Ave
 (If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Ada Mary Philamena De Groot

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Jan De Groot

7. Birth date of

deceased (mo., day, yr.)

Sept-17-1883

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

64322

hrs.

min.

9. Birthplace

England
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Jan 12 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 9 19 48 at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec - 26 19 44 to Dec - 9 19 48and that I last saw him/her alive on Jan - 7 19 48

Immediate cause of death

Adeno-Carcinoma
L. Breast

DURATION

3 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Cancer - Breast

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Lloyd Johnson M. D. or otherAddress Catonsville Md Date signed 1/10/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 16 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 138 BC 00200 4

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 13 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Fort Howard, Md.How long in hospital or institution? 13 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 417 E. Hamburg St.
(If rural, give LOCATION)2. (a) if veteran, name war Spanish-American War ✓

3. (a) FULL NAME

CHARLES T. DEHN

3. (b) Social Security Number

Unknown

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Deceased

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.) February 3, 1869

8. AGE:

Years

Months

Days

If less than one day

78117

hrs.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER

12. Name Deceased (name unknown)13. Birthplace Baltimore, Maryland

MOTHER

14. Maiden name Cora Trumbow15. Birthplace Baltimore, Maryland16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 1-13-1948
(month) (day) (year)Cemetery or crematory Cedar HillLocation a a Co. Md.

18. Funeral director

Address

Flynn + Fleming
1426 Light St.

19. Date rec'd by registrar

Jan 12 19 48A. W. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 19 48 at 2:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 28 19 47 to Jan. 10 19 48and that I last saw him alive on January 10 19 48Immediate cause of death PULMONARY TBC., BILATERAL, FAR-ADVANCED. DURATION 2 yrs.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE P. O. Anderson P. O. ANDERSON, M. D.VAH, FORT HOWARD, MARYLAND M. D. or otherAddress _____ Date signed 1/10/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00201 K2

1. PLACE OF DEATH

County Baltimore
City or town Rosemont
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs.
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Rosemont
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2900 Pennsylvania Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

Jerome Edward Dietrich

3. (b) Social Security Number

212-07-9890

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Minnie T. Dietrich

7. Birth date of deceased (mo., day, yr.) September 10, 1887 6.(c) If alive, give age 55 years

8. AGE: Years 60 Months 4 Days 9 If less than one day
..... hrs. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual occupation Electrician

11. Industry or business Retired

12. Name Robert J. Dietrich

13. Birthplace Maryland

14. Maiden name Hattie Wallace

15. Birthplace Maryland

16. Informant Mrs. Minnie T. Dietrich

Address 2900 Pennsylvania Ave.

17. Burial Date thereof 1-22-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Meadowridge Memorial Park

Location Harford County Maryland

18. Funeral director George L. Stewart

Address 2101 Frederick Ave. Balto.

19. 1/20 48 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 1948 at 3:15 AM

21. I CERTIFY that death occurred on the day above stated; that I attended deceased from Jan 10 1948 to Jan 19 1948
and that I last saw him alive on Jan 19 1948

Immediate cause of death Cerebral Hemorrhage DURATION 2 day

Due to

Due to

Other conditions

Diabetes Mellitus - 2 years
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Schimpf M. D. or other

Address no address Date signed 1/19/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

528

00202

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.
 City or town Stansbury Estate
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
1313 Second St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto
 City or town Stansbury Estate
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1313 Second St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Harry Clarence Downey

3. (b) Social Security Number

171-15-7460

4. Sex M 5. Color or race W. 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Beatrice Greenwood

7. Birth date of deceased (mo., day, yr.) Dec 26 - 1884 6. (c) If alive, give age years

8. AGE: Years 63 Months 0 Days 17 It less than one day hrs. min.

9. Birthplace Indiana Pa
 (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name John Downey

13. Birthplace Pa

14. Maiden name Ellen Wink

15. Birthplace Pa

16. Informant Miss Grace E Downey

Address 1313 Second St.

17. Burial Date thereof 1-15-48
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Linden Park

Location Frederick Rd

18. Funeral director John G Connolly

Address 422 Eastern Ave.

19. 1-13-48 19 48 John G Connolly
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 19 48 at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19 47 to Jan. 13 19 48
 and that I last saw him alive on Jan. 13 19 48

Immediate cause of death Exemia DURATION 6 mo.

Due to Metastatic 1 yr

Due to Carcinoma 4 yrs

Other conditions bladder 5 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mens of injury Injured at work?

23. SIGNATURE Joseph Miceli MD

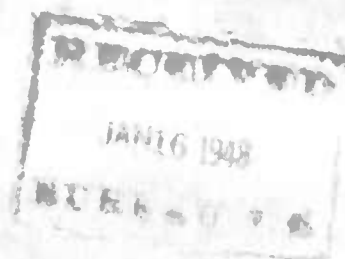
M. D. or other

Address 422 Eastern Ave Date signed 1/13/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct size is especially important. Physicians: please write the causes of death clearly and legibly.



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

00203

1. PLACE OF DEATH

County Balto.Village or City CatonsvilleRegistration Dist. No. 30

No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S. if of foreign birth?

yrs.

mos.

ds.

2. FULL NAME

(a) Residence: No.

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Col.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year)

June 27, 1869

7. AGE

78

Years

Months

Days

If LESS than

1 day, --- hrs.

or --- min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

Gardner

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country)

St. Marys Co. Md.

FATHER

13. NAME

William E. E. S.

14. BIRTHPLACE (city or town) (State or country)

St. Marys Co. Md.

MOTHER

15. MAIDEN NAME

Sarah Casanary

16. BIRTHPLACE (city or town) (State or country)

Carroll Co. Md.

17. INFORMANT

(Address)

John C. Wheeling
2101 Druid Hill Ave.

18. BURIAL, CREMATION, OR REMOVAL

Place

Western Star Cem.

Date

1-1148

19. UNDERTAKER

(Address)

Mrs. Katie R. Williams
322 N. Schroeder St.

20. FILED

1/9/48

19

A. W. Hedgcock

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

Jan.648

(Month)

(Day)

(Year)

22.

I HEREBY CERTIFY, That I attended deceased from

I last saw him live on Jan 6, 1948to have occurred on the date stated above, at 11:00 m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Cardiovascular
arteriosclerosis
hypertension

Data of onset

Other Contributory Causes of Importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of Injury

19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

M. D.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00204

1. PLACE OF DEATH:

County Balto

City or town Middle River
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balto

City or town Middle River
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8 S. Harrison Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Harry R. Finnell

3. (b) Social Security Number

406-07-6997

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Elsie Finnell ne Clark

7. Birth date of deceased (mo., day, yr.) Aug. 1st 1904 6. (c) If alive, give age 24 years

8. AGE: Years 43 Months 5 Days 12 It less than one day hrs. min.

9. Birthplace Richmond, Kentucky
(Town, county, and state)

10. Usual occupation clerk

11. Industry or business Glenn L. Martin Co.

12. Name Otto Finnell

13. Birthplace Kentucky

14. Maiden name Mary Spence

15. Birthplace Kentucky

16. Informant Mrs. Elsie Finnell

Address 310 Marilyn Ave. Essex

17. Transportation Date thereof Jan. 14-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Berea, Kentucky

Location John G. Connolly

18. Funeral director John G. Connolly

Address 418 Eastern Ave. Balt.

19. 1-14-48 19 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 13 19 48 at 7:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19 19

Immediate cause of death Carbon Monoxide Poisoning

Delummary Gas

Due to Carbon Monoxide Poisoning

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 1/13/48

Accident, suicide, or homicide suicide Date of 1/13/48

Where did injury occur? Middle River - Balt. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury TURNED ON GAS Injured at work? no

23. SIGNATURE M. G. Davis MD

Wm. H. Spence (Baltimore) or other

Address 1-14-48 Date signed 1/15/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 16 1948
BUREAU V E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore
City or town Near Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Ormscoat Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balt. City
City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 100 W. University Pkwy.
(If rural, give LOCATION)
2.(a) If veteran, name war. None

3. (a) FULL NAME

Elizabeth Boyd Fleming

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife Single
6.(c) If alive, give age. - years
7. Birth date of deceased (mo., day, yr.) Dec-5-1862
8. AGE: Years 85 Months 1 Days 17 If less than one day
hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation None
11. Industry or business None
FATHER 12. Name John Perkins Fleming
13. Birthplace Baltimore, Md.
MOTHER 14. Maiden name Elizabeth Smith
15. Birthplace Baltimore, Md.

16. Informant Mrs. Katharine F. Schmeisser
Address 110 Tunbridge Road.
17. Burial Date thereof Jan 24/48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Greenmount
Location Baltimore City
18. Funeral director Stewart & Mowson Company
Address 108-20 North Ave. City #1
19. 23 48 D.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 19 48 at 3:45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 20 to Jan 22 19 48
and that I last saw him alive on January 22 19 48

Immediate cause of death Lobar Pneumonia

DURATION

4 days

Due to
Due to
Other conditions Ante-natal hypochloremic acidosis & Prim 6 1920
Pneumonia of Puerper
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Cas. W. Judd M.D.
M. D. or other
Address 722 Wenden Road Balt. 18 Date signed 1/23/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00206

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

74

13

hs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

Burial, cremation, or removal. Which?

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

(Date rec'd by registrar)

19.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 9

1948

at

5:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1948

to

Jan. 1

1948

and that I last saw him alive on

Immediate cause of death

Cerebral Hemorrhage -

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00208

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town 28 Southland Court
(If outside city or town limits, write RURAL and give nearest town)
Street No. Towson, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Edith Green Fryer

3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Norman Fryer

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1885

8. AGE: Years 62 Months 7 Days 20 If less than one day hrs. min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)

10. Usual occupation Homemaker

11. Industry or business

12. Name Dr. John S. Green

13. Birthplace Hanford Co., Md.

14. Maiden name Ella Baldwin

15. Birthplace Balto. Co., Md.

16. Informant Dr. John Green

Address Towson, Md.

17. Burial Date thereof 1-16-48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Chesnut Grove

Location Sweet Air, Balto. Co., Md.

18. Funeral director Landon M. Brooks

Address 3000 York Rd.

19. (Date rec'd by registrar) Jan 15 1948 Registrar John S. Green

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14th 1948 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947 to Nov. 13 1948

and that I last saw her alive on Nov. 13th 1948

Immediate cause of death Asphyxiation by Gas

Other conditions

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 1/14/48

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John S. Green M.D. M. D. or other

Address Towson 4 - Md. Date signed 1/14/48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 4 1948

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 85

1. PLACE OF DEATH:

County Baltimore
City or town Rural near Freeland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 54 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Rural near Freeland.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1 mi. East of Freeland.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

Annie May Gessford.

3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow.

6.(b) Name of husband or wife Charles Gessford.
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 7, 1869.

8. AGE: Years 78 Months 11 Days 27 hrs. min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business Own home.

12. Name George Briggs.

13. Birthplace Md.

14. Maiden name Caroline Heathcote

15. Birthplace Md.

16. Informant Mrs. Edward Heathcote.

Address Md. Line, Md.

17. Burial Date thereof January 9, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Zion Cemetery

Location Freeland, Baltg. Co., Md.

18. Funeral director Jacob Harpstein

Address New Freedom Pa.

19. Jan 9 1948 Charles J. Quinn Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4 1948 at 1 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h. alive on 19

Immediate cause of death Coronary artery disease
death on arrival, probably

Due to coronary artery disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work?

23. SIGNATURE C. M. France M. D. or other

Address Parkton, Ind. Date signed 1/8/48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 15 1948

BY MAIL

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00209

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore Pikesville
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred:

6010 Bristow Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. CountyCity or town Balto. 14
 (If outside city or town limits, write RURAL and give nearest town)Street No. 3208 Chesley Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mary Rebecca Bontrun

3.(b) Social Security Number

4. Sex F5. Color or race W6.(a) Single, married, widowed, or divorced M6.(b) Name of husband or wife John C. Bontrun7. Birth date of deceased (mo., day, yr.) Oct. 5, 18818. AGE: Years 66 Months 3 Days 24 It less than one day6.(c) If alive, give age 66 years9. Birthplace Baltimore County
 (Town, county, and state)10. Usual occupation HW

11. Industry or business

12. Name Joseph Christopher13. Birthplace Balt. Co.14. Maiden name Josephine15. Birthplace Balt. Co.16. Informant John C. BontrunAddress 3208 Chesley Ave. Balto. Md.17. Burial Date thereof 2/2/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Parkwood CemLocation Taylor Ave18. Funeral director Leonard J. RuckAddress 5205 Heford Rd.19. 1/30/48 A. H. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 January 1948, at 7:15 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

25 Jan. 1948, to 29 Jan. 1948

and that I last saw h. alive on 19.....

Immediate cause of death Pulmonary edemaDue to Hypertensive C.V.D.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Charles F. Williams M.D.
 M. D. or otherAddress Pikesville 8, Md. Date signed 29 Jan 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00210

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred:
V. A. H. Fort Howard, Md.
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State New York County
City or town New York
(If outside city or town limits, write RURAL and give nearest town)
Street No. 514 Lennox Ave.
(If rural, give LOCATION)
2. (a) If veteran, name war WW II

3. (a) FULL NAME
MINGO E. GOODSON, JR.

3. (b) Social Security Number
Unknown

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Separated
6. (b) Name of husband or wife Mary Goodson
7. Birth date of deceased (mo., day, yr.) June 26, 1920 6. (c) If alive, give age ? years
8. AGE: Years 27 Months 6 Days 8 It less than one day hrs. min.

9. Birthplace Portsmouth, Va.
(Town, county, and state)
10. Usual occupation Chauffeur
11. Industry or business
12. Name Mingo E. Goodson, Sr.
13. Birthplace Portsmouth, Va.
14. Maiden name Elle ?
15. Birthplace North Carolina

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial Date thereof 1-8-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Body shipped to New York City
Location N.Y. for burial
18. Funeral director Charles R. Law
Address 802 Madison Ave., Balto., Md.

19. 1/6 xs A. W. Hedrick
(Date rec'd by registrar) 19 48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4, 19 48 at 3:25 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 28, 19 47 to Jan. 4, 19 48
and that I last saw him alive on January 4, 19 48

Immediate cause of death
Pulmonary Tuberculosis, act. far
advanced bilateral

DURATION
4 Mos.
plus

Due to
Due to
Other conditions Meningeal Tuberculosis 1 week
plus
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE P. J. Scott M. D. or other
R. J. SCOTT, M. D.
Address V. A. H. FORT HOWARD, MD. Date signed 1-5-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00211

Reg. Dist. No. 30

1. PLACE OF DEATH:

County... Baltimore
 City or town... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Maryland County...
 City or town... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 207 E. North Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war... -

3. (a) FULL NAME

SARAH ELIZABETH GRAFFLIN

3. (b) Social Security Number

4. Sex f 5. Color or race w 6. (a) Single, married, widowed, or divorced single
 6. (b) Name of husband or wife single
 7. Birth date of deceased (mo., day, yr.) February 26, 1870
 6. (c) If alive, give age _____ years
 8. AGE: Years 77 Months 10 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace... Maryland (Baltimore)
 (Town, county, and state)
 10. Usual occupation... teacher
 11. Industry or business... retired 1934
 12. Name... George W. Grafflin,
 13. Birthplace... Virginia (Winchester)
 14. Maiden name... Mary P. Wright
 15. Birthplace... Indiana

16. Informant... Hospital records
 Address... Catonsville 28, Md.

17. Burial Date thereof 1/24/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Druid Ridge Cem.
 Location... Pikesville, Md.

18. Funeral director... WM. J. TICKNER & SONS
 Address... Balto., Md.

19. 1/22 48 A.W. Hedrick
 (Date read by registrar) (Year) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... January 21 19 48 at 10:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12 19 48 to January 21 19 48
 and that I last saw him alive on January 21 19 48

Immediate cause of death... Generalized arteriosclerosis DURATION Indef.
 Due to... Arteriosclerotic heart disease Indef.
 Due to... Cerebral arteriosclerosis Indef.

Other conditions... _____

(Include pregnancy within 8 months of death)

Major findings of operations... _____

Date of op. _____

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE... Isadore Tuerk, M.D.

Catonsville 28, Md. M. D. or other
 Address... Date signed 1/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00212

Reg. Dist. No. 40

1. PLACE OF DEATH: Baltimore
 County Kingsville, Md.,
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Kingsville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Belair Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME William H Green
 3. (b) Social Security Number

4. Sex male
 5. Color or race white
 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Ethel E. Green
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) April 9th, 1884
 8. AGE: Years 63 Months 9 Days 19 If less than one day hrs. min.

9. Birthplace Baltimore County, Md.,
 (Town, county, and state)
 10. Usual occupation Storekeeper
 11. Industry or business

12. Name Charles H. Green
 13. Birthplace Baltimore County, Md.,
 14. Maiden name Amelia Seidel
 15. Birthplace Baltimore County, Md.,

16. Informant Mrs. W.H. Green
 Address Belair Rd., Kingsville, Md.

17. burial Date thereof 1/31/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Johns
 Location Blenheim, Md.

18. Funeral director Lescage Funeral Home
 Address 7401 Belair Rd.

19. 2/2/28 19 St. M. Hammel
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1948 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-22 1943 to 1-28 1948
 and that I last saw him alive on Jan 28 1947

Immediate cause of death Pulmonary Embolus
 DURATION 15 min

Due to Coronary disease with Hypertension
 DURATION 5 yrs

Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Fred O. Hodous M.D.
 Address Edgewood Md Date signed 1-28-48
 M. D. or other

RECEIVED

FEB 3 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

00213

93d

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville 28, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 yrs. 9 mos. 12 das.
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 13 yrs. 8 mos. 12 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Alberton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

Tressie Greene

3. (b) Social Security Number

None

4. Sex f 5. Color or race w 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Walter E. Greene
 7. Birth date of May 15, 1897 6. (c) If alive, give age _____ years
 deceased (mo., day, yr.)
 8. AGE: Years 50 Months 7 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Virginia
 (Town, county, and state)
 10. Usual occupation housewife
 11. Industry or business Home
 12. Name John Settles
 13. Birthplace Virginia
 14. Maiden name Ida Forsythe
 15. Birthplace Virginia

16. Informant Hospital records
 Address Catonsville-28, Maryland
 17. Burial Date thereof Jan. 9, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National Cem
 Location Arlington Va.
 18. Funeral director Easton Sons
 Address Edlicott City, Md.
 19. Jan. 7, 1948 V.E. Harry
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5, 1948 at 6:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25, 1934 to January 5, 1948
 and that I last saw h. er alive on January 5, 1948

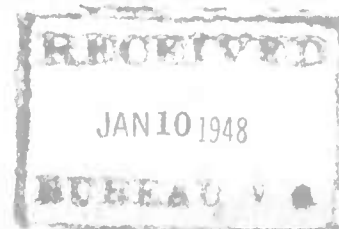
Immediate cause of death Massive intraventricular hemorrhage
 Due to Malignant hypertensive cardio-vascular disease
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

DURATION

12 hours
indefinite

Major findings of operations _____ Date of op. _____
 Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, pub'c place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Isadore Tuerk, M.D. M. D. or other
 Address Catonsville-28, Md. Date signed 1-6-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00214

BC

Reg. Dist. No.

44

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Maryland
How long in hospital or institution? 23 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 336 W. Preston Street
(If rural, give LOCATION)
2. (a) If veteran, name war WW-I

3. (a) FULL NAME

SAM GREGG

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Henrietta Gregg
6. (c) If alive, give age 34 years
7. Birth date of deceased (mo., day, yr.) June 20, 1896
8. AGE: Years 51 Months 6 Days 18 If less than one day hrs. min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual occupation Heater
11. Industry or business
12. Name Wesley Gregg
13. Birthplace South Carolina
14. Maiden name Emily MN: Unknown
15. Birthplace South Carolina

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial Date thereof 1-12-48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Balto. National Cemetery
Location Maryland

18. Funeral director A. Halstead
Address 918 Druid Hill Ave., Balto., Md.

19. 1-7 48 M. E. Pugh
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1948 at 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 16, 1947 to January 8, 1948 and that I last saw him alive on January 8, 1948

Immediate cause of death Lobar, Pneumonia, rt. upper lobe. DURATION Unknown

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. E. PUGH, M. D. M. D. or other
Address V.A.H. FORT HOWARD, MD Date signed 1-9-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of
year of birth is shown on
G 114 1/20/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *41*

00215

1. PLACE OF DEATH:

County *Baltimore - 19 -*City or town *Sparrows Point*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7308 Walman ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *As in # 1.* County *As in # 1.*City or town *As in # 1.*
(If outside city or town limits, write RURAL and give nearest town)Street No. *As in # 1.*
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JOHN HENRY GROVES

3. (b) Social Security Number

218-07-8065

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

*Widowed*8. (b) Name of husband or wife *Mary E Groves*

7. Birth date of

deceased (mo., day, yr.)

*Oct. 14. 1876/1877*6. (c) If alive, give age *—* years

8. AGE:

Years

Months

Days

If less than one day

*70**2**27**—* hrs.*—* min.

9. Birthplace

Baltimore - Md.
(Town, county, and state)

10. Usual occupation

Steel products - mfg.

11. Industry or business

Machinist

FATHER

12. Name

John Henry Groves

13. Birthplace

Baltimore Md.

MOTHER

14. Maiden name

Emma J. Young

15. Birthplace

Baltimore Md.

16. Informant

Mrs. Minnie Mc Donald

Address

As in # 1.

17. (Burial, cremation, or removal. Which?)

Burial Date thereof *1/14/48*
(month) (day) (year)

Cemetery or crematory

Oak Lawn Cemetery

Location

Baltimore Md.

18. Funeral director

Henry Sander & Sons

Address

North Ave. & Broadway

19. (Date rec'd by registrar)

*Jan 12 48**R. W. Hedrick*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Jan. 11 1948 at 8:45 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Mar. 6 1947 to Jan. 11 1948*and that I last saw him alive on *Jan. 8 1948*

Immediate cause of death

Coronary Occlusion

Due to

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*Louis H. Tallin M.D.**6908 N. P. Rd. Balto - 19. 1/14/48*

M. D. or other

Date signed *1/11/48*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00216

Reg. Dist. No. 40

1. PLACE OF DEATH

County Balto.City or town Fingerville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred:

Belair Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltoCity or town Fingerville
(If outside city or town limits, write RURAL and give nearest town)Street No. Belair Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edwin Hall Harkins

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mabel A. Harkins

7. Birth date of deceased (mo., day, yr.)

Sept. 16th 1865

6. (c) If alive, give age, years

8. AGE:

Years

82

Months

4

Days

7

If less than one day

hrs.

min.

9. Birthplace

Harford Co. Md.
(Town, county, and state)

10. Usual occupation

Truck farmer

11. Industry or business

Stephen Harkins

12. Name

Unknown

13. Birthplace

"

14. Maiden name

"

15. Birthplace

Mrs. E. H. Harkins

16. Informant

Belair Rd. Fingerville

17. Burial

(Burial, cremation, or removal. Which?)

Burial

Date thereof

Jan 26/48
(month) (day) (year)

Cemetery or crematory

Central Meth.

Location

Harford Co. Md.

18. Funeral director

Tabbarn Funeral Home

Address

7401 Belair Rd.1/24/48Edwin Harkins1/24/48

(Date rec'd by registrar)

19

19

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1948 at 630 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1946 to Jan 23 1948and that I last saw him alive on Jan 23 1948

Immediate cause of death

Cerebral Thrombosis

DURATION

3 days

Due to

Advanced General Atherosclerosis

Due to

Chronic arthritis

Other conditions

Chronic arthritisFevers

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

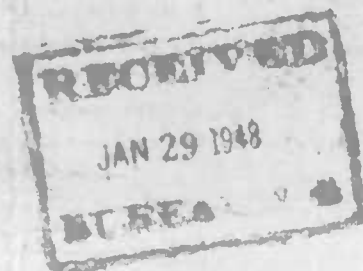
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Red O Hodors M.D.Edgewood Md M.D. or otherAddress Date signed 1-23-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 months 27 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 8 months 27 days

3. (a) FULL NAME

HAWKS, Monte

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Lena Burke (deceased)7. Birth date of deceased (mo., day, yr.) June 28, 1885

8. AGE: Years Months Days If less than one day

61617hrs. min.9. Birthplace Virginia
(Town, county, and state)10. Usual occupation Laborer11. Industry or business Labor.12. Name Osborne Hawks13. Birthplace Virginia14. Maiden name Alice Kingsberry15. Birthplace Virginia16. Informant Hospital RecordsAddress Catonsville-28, Maryland17. Burial Date thereof 2-13-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Spring Grove State HospitalLocation Catonsville 28, Md.18. Funeral director Spring Grove State HospitalAddress Catonsville 28, Md.19. 2-13 19 48 V E Harry
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 4506 Sorrento Avenue
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 19 48 at 2:05 p. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 19 47 to Jan. 14 19 48and that I last saw him alive on January 14 19 48Immediate cause of death Coronary sclerosis
due to arteriosclerotic cardio-
vascular disease; DURATIONDue to Cardiac decompensation; Indef.
Pneumonia, left base. Indef.Due to Undiagnosed Indef.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Tuerk, M. D. M. D. or otherAddress Catonsville-28, Maryland Date signed 2-6-48

RECEIVED

FEB 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *44*

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

V.A.H. Fort Howard, MarylandHow long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 3217 Phelps Lane
(If rural, give LOCATION)2.(a) If Veteran, name war World War I

3. (a) FULL NAME

ALBERT K. HELFRICH

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteMarried6. (b) Name of husband or wife Matilda Helfrich6. (c) If alive, give age 52 years7. Birth date of deceased (mo., day, yr.) August 24, 18888. AGE: Years Months Days If less than one day
59 4 29 hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Policeman

11. Industry or business

12. Name Albert Helfrich13. Birthplace Germany14. Maiden name Barbara Basil15. Birthplace Germany16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof 27 Jan 48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory New CathedralLocation Baltimore, Maryland18. Funeral director H. B. Whippert & SonAddress 300 E. Eutaw Place - 1719. 1/26/48 A. W. Hedrick
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1948 13:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

January 12 1948 to January 23 1948and that I last saw him alive on January 23 1948

Immediate cause of death DURATION

Thrombosis, left anterior descending coronary artery SuddenDue to Coronary Arteriosclerosis~~Other~~ Other Cond: 1. Generalized arterio-sclerosis, Duration & Cause Unknown2. Chr. Arteriosclerotic Nephritis UnknownOther conditions 3. Pulmonary Edema due to #1. Sudden4. Diverticulosis, sigmoid, cause: Unknown Unknown

Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. B. French A. B. FRENCH, M. D. M. D. or otherAddress V.A.H. Fort Howard, Md. Date signed 1-23-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 8300 RC 01036
 Reg. Dist. No. 37

1. PLACE OF DEATH:

County Baltimore
 City or town Cockeysville Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 1/2 yrs
 Hospital, institution, or street address where death occurred:
Masonic Home, Cockeysville Md
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 717 E. 23rd St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Annie C. Henneman

3. (b) Social Security Number

Information later from Masonic Temple

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Howard L. Henneman

7. Birth date of deceased (mo., day, yr.) Sept. 1 - 1867 6. (c) If alive, give age 70 years

8. AGE: Years 80 Months 4 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Cambridge Md
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Wm. N. Grace

13. Birthplace Easton Md.

14. Maiden name Ann Maria Cook

15. Birthplace Cambridge Md

16. Informant Laura M. Schroeder

Address Masonic Home, Cockeysville Md

17. Burial Date thereof 1-29-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Louden Park

Location Baltimore Md

18. Funeral director Wm. Cook

Address St. Paul + Preston St.

19. 1-27- 19 48 Laura M. Schroeder
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 19 48, at 9:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 46 to Jan 26 19 48, and that I last saw him alive on Jan 26 19 48.

Immediate cause of death Cerebral Hemorrhage DURATION 5 days

Due to Arterio Sclerosis 5 yrs?

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

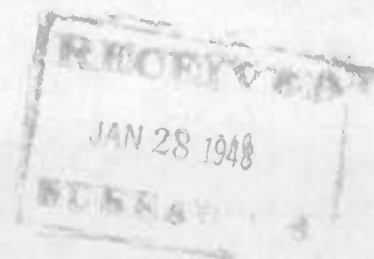
Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Walter J. Kees M.D.

Address Cockeysville Md M. D. or other _____

Date signed 1-26-48



Permanently

ARTESIAN LOGGER

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01037

Reg. Dist. No. 44

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 34 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Maryland
 How long in hospital or institution? 34 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 509 S. Potomac Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... WW-I

3. (a) FULL NAME

FRED W. HENNICK

3. (b) Social Security Number

Unknown 219-05-7960

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Single</u>
6.(b) Name of husband or wife..... <u>Single</u>		
7. Birth date of deceased (mo., day, yr.) <u>9-6-89</u>		
6.(c) If alive, give age..... years		
8. AGE: Years <u>58</u>	Months <u>4</u>	Days <u>0</u>
It less than one dayhrs.min.		

9. Birthplace..... Delaware
 (Town, county, and state)
 10. Usual occupation..... Chief Cook
 11. Industry or business.....
 12. Name..... Oscar Wm. Hennick
 13. Birthplace..... New York
 14. Maiden name..... Kate Miller
 15. Birthplace..... Pennsylvania

16. Informant..... Clinical Records, Vets. Adm. Hospital
 Address..... Fort Howard, Maryland

17. Burial Date thereof..... 1/8/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory..... Baltimore National Cemetery
Baltimore, Maryland
 Location..... Howard W. Blight Jr.
4914 Belair Rd., Balto., Md.
 18. Funeral director.....
 Address.....

19. 1-7-48 19 48
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 5, 19 48 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 3, 19 47 to January 5, 19 48
 and that I last saw him alive on January 5, 19 48

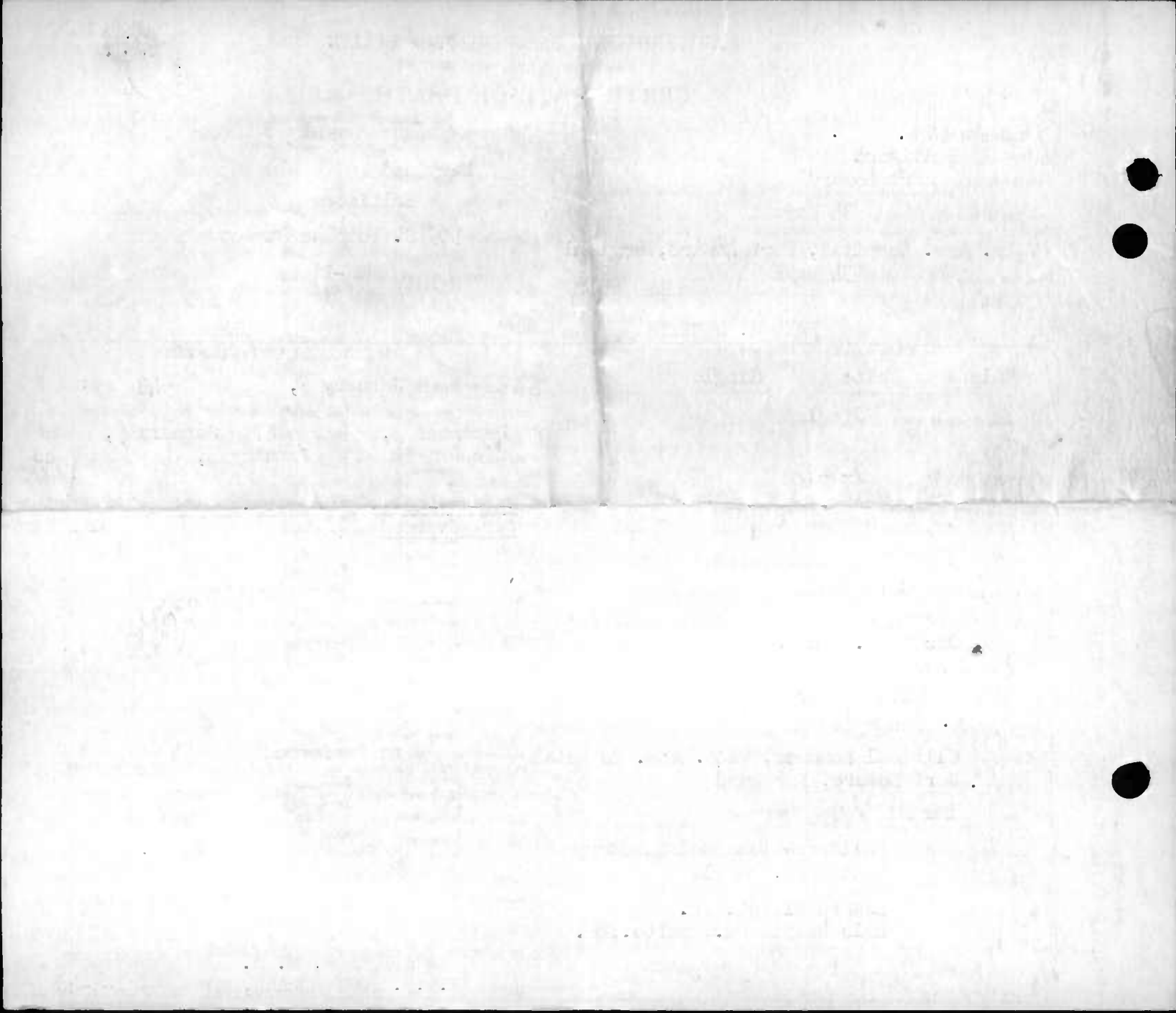
Immediate cause of death.....
Tuberculosis, pulmonary, bilateral
far advanced
 DURATION
2 Months plus

Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results..... None Performed
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE..... Jack Morrow
JACK MORROW, M. D. M. D. or other
 Address..... V.A.H. FORT HOWARD, MD Date signed 1-6-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01038

Reg. Diat. No. 20

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 months
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Balt. City
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 609 W. West St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Mary Johanna Herdegen

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Joseph Herdegen
May 11, 1872 deceased years
 7. Birth date of deceased (mo., day, yr.)
 8. AGE: Years 75 Months 7 Days 30 It less than one day hrs. min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation housewife
 11. Industry or business ---

FATHER 12. Name Fred. Bauer
 13. Birthplace Germany
 MOTHER 14. Maiden name Sarah Barbara Scareiner
 15. Birthplace Germany

16. Informant Louis M. Yingling (son)
 Address 609 W West St.

17. BURIAL Date thereof 1/13/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baltimore Cemetery
 Location North Ave

18. Funeral director Harry H. Witzke
 Address 4101 Edmondson Ave

19. 1/13 48 Y. E. Harry
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1948 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 8 1947 to January 10 1948

and that I last saw her alive on January 10 1948

Immediate cause of death Bronchopneumonia DURATION 1 mo.

Due to Hypertensive C-V disease yrs.

Due to Generalized Arterio-sclerosis yrs.

Other conditions Coronary Heart Disease indef.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

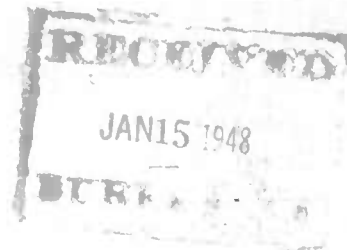
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. D. or other

Address: Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 190 42

1. PLACE OF DEATH:

County Relay
 City or town Baltimore C. Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 months

Hospital, institution, or street address where death occurred:

Relay Sanitarium Relay 27 Md.How long in hospital or institution? 24 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington D.C. County D.C.City or town Washington D.C.
 (If outside city or town limits, write RURAL and give nearest town)Street No. 1707 Columbia Rd.
 (If rural, give LOCATION)2.(a) If veteran, name war ✓

3. (a) FULL NAME

Mary Elizabeth Heyler

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single6.(b) Name of husband or wife Miss Mrs. Laura D. TerryJan 25, 1870 6.(c) If alive, give age 48 years7. Date of death (mo., day, yr.) Jan 16, 19488. AGE: Years 77 Months 11 Days 22 If less than one day hrs. min.9. Birthplace Hamilton, Ohio
 (Town, county, and state)10. Usual occupation none11. Industry or business none12. Name Christoph Heyler13. Birthplace Germany14. Maiden name Philippine Bender15. Birthplace Germany16. Informant Mrs. Laura D. TerryAddress 1707 Columbia Road Washington D.C.17. Removal Date thereof Jan 16, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Ignace CemeteryLocation Washington D.C.18. Funeral director J. William Lees Sons Co.Address 300 - 7th St. N.E. Washington D.C.19. January 48 (miss) E. B. Williams
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16, 1948 at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 13, 1946 to Jan 16, 1948and that I last saw him alive on Jan 16, 1948Immediate cause of death Cerebral thrombosisDue to thrombotic arteriosclerosisDue to arteriosclerosisOther conditions Arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations noneDate of op. noneAutopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of none

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) noneMeans of injury none Injured at work? none23. SIGNATURE Lewis P. Gandy M.D.Address Washington D.C.Date signed 1/16/48

RECEIVED
JAN 17 1948
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01040 43
Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
City or town Owens
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Baltimore
City or town Owens
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6 Chesney Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

Catherine Elizabeth Hitzelberger

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

8.(b) Name of husband or wife Edward Lester Hitzelberger

7. Birth date of deceased (mo., day, yr.) May 11, 1890 5.(c) If alive, give age 58 years

8. AGE: Years 57 Months 10 Days 14 If less than one day hrs. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name George Wascheit

13. Birthplace Maryland

14. Maiden name Elizabeth Ludwig

15. Birthplace Pennsylvania

16. Informant Edward L. Hitzelberger

Address 6 Chesney Ave.

17. Burial Date thereof 1-28-48
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Parkwood

Location Balto. County, Md.

18. Funeral director George F. Schwab

Address 2101 Frederick Avenue

19. 1/26/48 G.W. Helmer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 18. 48 at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that attended deceased from Jan 17 19. 48 to Jan 25 19. 48
and that last saw him 5 alive on Jan 25 19. 48

Immediate cause of death Coronary Artery Sclerosis

Due to Hypertension

Due to Chronic Cholelithiasis

Other conditions hepatic

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE Michael J. [Signature]

Address 5407 Balto. Rd.

Date signed 1-26-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 01041
Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Md.
How long in hospital or institution? 13 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County _____
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 217 E. Church Hill Street
(If rural, give LOCATION)
2. (a) If veteran, name war WW-I

3. (a) FULL NAME

HOLDEN, Archie A.

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Bertha Holden

7. Birth date of deceased (mo., day, yr.) 7-6-91 6. (c) If alive, give age 47 years

8. AGE: Years 56 Months 6 Days 4 It less than one day _____ hrs. _____ min.

9. Birthplace Moscow, Idaho
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business _____

FATHER 12. Name William Holden
13. Birthplace Washington

MOTHER 14. Maiden name Cora Hodge
15. Birthplace Washington

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial Date thereof 11/13/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Baltimore, Maryland
Location Howard N. Blight, Jr.
18. Funeral director 4914 Belair Rd., Balto., Md.
Address _____

19. 11/13/48 19 _____
(Date rec'd by registrar) Registrar A. W. Hedrick

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10, 1948 at 6:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 28, 1947 to January 10, 1948
and that I last saw him alive on January 10, 1948

Immediate cause of death Pulmonary Tuberculosis, bilateral
Far Advanced DURATION Unknown

Due to _____
Due to _____

Other conditions Tuberculosis of Gastro-intestinal tract & spleen
(Include pregnancy within 3 months of death) Unknown

Major findings of operations _____
Date of op. _____

Autopsy results Substantiated Above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE W. H. Heath M. D. or other _____
Address V.A.H. FORT HOWARD, MD. Date signed 1-10-48

MARGIN RESERVED FOR BINDING

I

VS A15 9:45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **0104243**

1. PLACE OF DEATH:

County **Baltimore**
City or town **Fullerton, Md.**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **25 years**
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State **Maryland** County **Baltimore**
City or town **Fullerton, Md.**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **9207 Ridge Ave.**
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

ROBERT E. HOPPS

3. (b) Social Security Number

212-10-7151

4. Sex **male** 5. Color or race **white** 6.(a) Single, married, widowed, or divorced **married**
6.(b) Name of husband or wife **Elnora J. Hopps**
7. Birth date of deceased (mo., day, yr.) **Jan. 9th, 1889**
6.(c) If alive, give age years
8. AGE: Years **59** Months **6** Days **6** If less than one day
.....hrs.min.

9. Birthplace **Baltimore, Md.**
(Town, county, and state)
10. Usual occupation **Foreman**
11. Industry or business **G.L. Martin Co.**

12. Name **Robert S. Hopps**
13. Birthplace **Unknown**
14. Maiden name **Unknown**
15. Birthplace **Unknown**

16. Informant **Mrs. R.E. Hopps**
Address **9207 Ridge Ave.,**

17. **burial** Date thereof **1/19/48**
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory **Oak Lawn**
Baltimore, Md.
Location

18. Funeral director **Lassahn Funeral Home**
Address **7401 Belair Road**

19. **1-17** 19 **48**
(Date rec'd by registrar) **a.w. Hedrich** Registrar

MEDICAL CERTIFICATION

Jan. 15th, 48 8:50P

20. DATE OF DEATH.....19.....at.....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Jan. 25** 19 **47**, to **Jan. 15** 19 **48**
and that I last saw him alive on **Jan. 13** 19 **48**
Immediate cause of death.....

Due to **Coronary Occlusion**
Chronic myocarditis
Other conditions.....

(Include pregnancy within 3 months of death)
Major findings of operations..... Date of op.
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE **J. Sklar** M. D. or other
Address **9122 Rockwood Rd** Date signed **16 Jan 48**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1312 01043

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

Vet. Adm. Hosp. Fort Howard, Md.How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 4113 Northern Parkway
(If rural, give LOCATION)2.(a) If veteran, name war WW I

3. (a) FULL NAME

LOUIS H. HUDSON4. Sex MALE 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Elizabeth Hudson7. Birth date of deceased (mo., day, yr.) March 10 1899 6. (c) Give age 44 years
January 2, 19488. AGE: Years 56 Months 10 Days 11 If less than one day
.....hrs.min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Robert F. Hudson13. Birthplace Baltimore, Md.14. Maiden name Annie Starr15. Birthplace Maryland18. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof 1 24 48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Balto National Cem.Location Frederick Rd18. Funeral director The Dippel Bros.Address 7110 Belair Rd19. 1/23 88 A.W. Hedrick
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1948, at 9:21 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 9 1948, to January 21 1948
and that I last saw him alive on January 21 1948Immediate cause of death Uremia DURATION 5 daysDue to Hypertensive cardio-renal disease 5 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. E. PUGH, M.D. M. D. or otherAddress Vets. Adm., Fort Howard, Md. Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County BaltimoreCity or town Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since Sept 27, 1947Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.How long in hospital or institution: Since Sept 27, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 13 Rimwood Ave
(If rural, give LOCATION)2.(a) If veteran, name war ✓

3. (a) FULL NAME

Geraldine Rose Urby Urby

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Charles E. Urby7. Birth date of deceased (mo., day, yr.) October 10, 1920 8. (c) If alive, give age 27 years8. AGE: Years 27 Months 3 Days 16 If less than one day9. Birthplace Baltimore Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Frank Knight13. Birthplace W Virginia14. Maiden name Mary Norton15. Birthplace Baltimore Md16. Informant Personal History - Hospital RecordsAddress Eudowood Sanatorium, Towson 4, Md.17. Burial Date thereof 1-28-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Catholic Cem.Location Baltimore18. Funeral director George A. FarleyAddress Fulton Ave + Fayette St19. 1/28 19 48 A.W. Hedrich
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 19 48 at 5:15 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 27, 1947 to Jan 26 19 48and that I last saw him alive on January 26 19 48Immediate cause of death Pulmonary tuberculosisDue to Since May 1939Due to 1939

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Meane of injury Injured at work?

23. SIGNATURE W. H. Bridges M. D. op. 1-26-48Address Towson 4, Md. Date signed 1-26-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01044

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 26 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
 How long in hospital or institution? 26 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County
 City or town Baltimore (23)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1006 W. Baltimore Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war WW-I ✓

3. (a) FULL NAME

LEO F. JIRSA

3. (b) Social Security Number

unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Widowed - Elizabeth
 7. Birth date of deceased (mo., day, yr.) 5-25-93 6. (c) If alive, give age years
 8. AGE: Years 54 Months 8 Days 1 It less than one day hrs. min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

12. Name William Jirsa
 13. Birthplace Germany
 14. Maiden name Mary Sauers
 15. Birthplace Germany

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Maryland

17. Burial Date thereof 1/29/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Oak Hill
 Location Baltimore

18. Funeral director Leonard J. Ruck
 Address 5305 Hanford Road

19. January 27 48 A. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 19 48, 12:00 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 31, 19 47, to January 26, 19 48

and that I last saw him alive on January 26, 19 48

Immediate cause of death TUBERCULOSIS, PULMONARY,
BILATERAL, FAR-ADVANCED, ACTIVE DURATION 1 mo. plus

Due to

Due to

Other conditions Chronic Nephritis Unknown
Encephalomalacia 3 yrs. plus
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE V. SCIULLO, M.D. M. D. or other

Address V.A.H. FORT HOWARD, MD. Date signed 1-26-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01046

830

BC

Reg. Dist. No. 20

1. PLACE OF DEATH:

County..... Balto
City or town..... Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Opitz Nursing Home (Nunnery Lane)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... MD County.....
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4446 Wrenwood Ave
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Lillie L. Johnson

3. (b) Social Security Number

4. Sex..... Female
5. Color or race..... White
6. (a) Single, married, widowed, or divorced..... Single
6. (b) Name of husband or wife.....
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.)..... Nov. 25th 1867
8. AGE: Years..... 80 Months..... 1 Days..... 17 If less than one day..... hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 12th 1948 at..... 330 A
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... Jan 2 1948 to..... Jan 12 1948
and that I last saw him alive on..... Jan 11 1948
Immediate cause of death..... Cerebral Hemorrhage
DURATION..... 2 days
Due to..... Cerebral Arterio
Due to..... Sclerosis
Other conditions.....
(Include pregnancy within 5 months of death)

9. Birthplace..... Balto. Md.
(Town, county, and state)
10. Usual occupation..... Retired Saleslady
11. Industry or business..... May Co.
12. Name..... William T. Johnson
13. Birthplace..... Md.
14. Maiden name..... Mary E. Hackney
15. Birthplace..... Md.
16. Informant..... Mrs. Ida A. Mcraig
Address..... 4446 Wrenwood Ave
17. Burial..... Burial Date thereof..... 1/12/48
(Burial, cremation, or removal, which?) (month) (day) (year)
Cemetery..... Landon Park
Location..... Balto. Md.
18. Funeral director..... William Cook Inc.
Address..... 1217 St. Paul St
19. Jan 14 1947 A. W. Hedrick
(Date rec'd by registrar) Registrar

Major findings of operations..... Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, pub'c place (where?)
Means of injury..... Injured at work?
23. SIGNATURE..... James Howard
M. D. or other
Address..... Catonsville Date signed..... 1-13

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 49

1. PLACE OF DEATH:

County BaltimoreCity or town Turner's Sta - rr - Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sandra Johnson

3. (b) Social Security Number

4. Sex

F

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8-23-47

8. AGE:

Years

Months

Days

It less than one day

430

hrs.

min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Bruce Johnson

13. Birthplace

S.C.

MOTHER

14. Maiden name

Annie Stephenson

15. Birthplace

S.C.

16. Informant

Bruce Johnson

Address

130 Blane way - Turner's Sta

17.

(Burial, cremation, or removal, Which?)

Burial

Date thereof

1-24-48
(month) (day) (year)

Cemetery or crematory

mt. Auburn

Location

Baltimore Md.

18. Funeral director

Charles R. Law

Address

802 mad. ave.

19.

Date rec'd by registrar

19 48A. W. Hedrick

B. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Baltimore

City or town

Turner's Sta - rr -

(If outside city or town limits, write RURAL and give nearest town)

Street No.

130 Blane Way -

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

JAN. 22

19

48 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h..... alive on..... 19

Immediate cause of death

Central P. Int. Injury

DURATION

5 min

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

1/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 45 yrs

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balto.City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)Street No. 110 Sudbrook Ave
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Joanna Elizabeth Kahoe

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Edward Michael KahoeDeceased 6. (c) If alive, give age _____ years7. Birth date of deceased (mo., day, yr.) Sept. 18, 18668. AGE: Years 81 Months 3 Days 24 If less than one day _____ hrs. _____ min.9. Birthplace Ireland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Daniel P. Lynch13. Birthplace Ireland14. Maiden name Mary Lynch15. Birthplace Ireland16. Informant Mrs. L. M. VolzAddress 110 Sudbrook Ave. Pikesville17. Burial (burial, cremation, or removal, Which?) Burial Date thereof Jan 16, 1948
(month) (day) (year)Cemetery or crematory Gruid RidgeLocation Pikesville, Maryland18. Funeral director Frank H. SpurrellAddress Pikesville, Maryland19. 1-15- 19 48 E. E. Nichols
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13, 1948 at 7:46 P M21. CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 9 1948 to Jan 13 1948and that I last saw her alive on Jan 13 1948Immediate cause of death Coronary ThrombosisDue to Chronic MyocarditisDue to Arterio SclerosisOther conditions Senility

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. E. Nichols M.D. M. D. or otherAddress Pikesville, Md Date signed 1-15-48

RECEIVED

RECEIVED

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RECEIVED
JAN 16 1948
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

01049

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 months
 Hospital, institution, or street address where death occurred:
7102 Deerfield Road
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Chesapeake
 City or town Lanedowne
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hammonds Ferry Road
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Carrie Wilhelminia Kaiss

3. (b) Social Security Number

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Frank Kaiss

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1870 6. (c) If alive, give age _____ years

8. AGE: Years 77 Months 10 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Germany
 (Town, county, and state)

10. Usual occupation H.W.

11. Industry or business _____

MOTHER FATHER 12. Name Seihler

13. Birthplace Germany

14. Maiden name _____

15. Birthplace Germany

16. Informant Mrs. Virginia W. Kaiss

Address 7102 Deerfield Road, Pikesville 8, Md.

17. BURIAL Date thereof 1/12/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory LORRAINE

Location BALTIMORE, MD.

18. Funeral director WM. J. TICKNER & SONS, INC.

Address North + B. Aves, BALTO, MD.

19. Jan 12 19 48 C. W. Hedrick

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 January 19 48, at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 October 19 48, to 9 January 19 48

and that I last saw him alive on 8 January 19 48

Immediate cause of death _____

Arteriosclerosis, cerebral

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Charles H. Williams M.D.

M. D. or other _____

Address Pikesville 8, Md. Date signed 9 Jan 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01050

48

1. PLACE OF DEATH:

County BaltimoreCity or town Lodge Forest
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Frank J. Keinonen

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Josephine Keinonen

7. Birth date of deceased (mo., day, yr.)

Sept. 17, 1888

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

59227

hrs.

min.

9. Birthplace

Finland
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Finland

14. Maiden name

Matilda

15. Birthplace

Finland

16. Informant

Mrs Josephine Keinonen

Address

7751 North Point Creek Rd. Sparrows Point

17.

Burial
(Burial, cremation, or removal, Which?)

Date thereof

Jan. 17, 1948
(month) (day) (year)

Cemetery or crematory

Oaklawn

Location

Eastern Blvd., Balto. Co.

18. Funeral director

Roland L. Fisher

Address

2112 Dundalk Ave

19.

Jan 16 - 48
(Date rec'd by registrar)Demetrius L. Harber
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Baltimore

City or town

Lodge Forest - Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)

Street No.

7751 North Point Creek Road
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 13,

19

48, at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June

19

47, toJanuary

19

and that I last saw him

alive on

January 3

19

48

Immediate cause of death

Cerebral metastasis

DURATION

8 mo.

Due to

Generalized Carcinoma -focus-focus undetermined

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Jose N. Borden M.D.

M. D. or other

Address

1109 N. Calvert St.

Date signed

14 January 48

RECEIVED
JAN 19 1948
ST. PAUL, MINN.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01051

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Opitz Nursing Home
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3620 Edmondson Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war No

3. (a) FULL NAME

DAVID KINDLE

3. (b) Social Security Number
None

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife Mary Ellen
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) May 1, 1857
 8. AGE: Years 90 Months 8 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Woodstock, Howard Co., Md.
 (Town, county, and state)
 10. Usual occupation Retired Clerk-- P. RR.
 11. Industry or business
 12. Name William Kindle
 13. Birthplace Maryland
 14. Maiden name Eliza Nichols
 15. Birthplace Maryland

16. Informant Mrs. Wm. M. Showbridge
 Address 3620 Edmondson Ave; Balto., Md.
 17. Burial xxxx Cedar Hill Cem. Date thereof 1/31/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematorium Baltimore County, Md.
 Location Baltimore County, Md.
 18. Funeral director WM. J. TICKNER & SONS INC
 Address North & Pa. Aves; Balto., Md.
 19. 1/30/48 R. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28, 1948 19 5:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 26 19 48 to Jan 28 19 48
 and that I last saw him alive on Jan 28 19 48

Immediate cause of death Broncho Pneumonia DURATION 3 days
 Due to
 Due to
 Other conditions Cardio Vascular: Pulmonary disease 2 1/2 yrs
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Joseph A. Zierler M.D. M. D. or other
23/8 Eastern Ave Date signed Jan 29/48
 Address _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 16 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.
 How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 400 W. 28th St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war WW I

3. (a) FULL NAME

CLARK E. KING

3. (b) Social Security Number

194-07-0977

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife <u>Margaret C. King</u>		
7. Birth date of deceased (mo., day, yr.) <u>April 11, 1896</u> <u>January 21, 1948</u>		
8. AGE:	Years	Months
	<u>51</u>	<u>6 9</u>
	Days	It less than one day
	<u>10</u>	hrs. min.
9. Birthplace <u>Nazareth, Pa.</u> (Town, county, and state)		
10. Usual occupation <u>Oil Burner Electrician</u>		
11. Industry or business <u>Glenn L. Martin Co.</u>		
FATHER	12. Name <u>Charles King</u>	
	13. Birthplace <u>Pennsylvania</u>	
	14. Maiden name <u>Alice Gold (Alice L. Gold)</u>	
MOTHER	15. Birthplace <u>Pennsylvania</u>	

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Maryland

17. Burial Date thereof Jan. 24, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baltimore National Cemetery
 Location Baltimore, Md.

18. Funeral director W. E. McMillan
 Address 4510 Liberty Heights Ave.

19. 1/22 19 48 A. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 19 48 at 4:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 5 19 48 to January 21 19 48
 and that I last saw him alive on January 21 19 48

Immediate cause of death
Encephalomyelitis, cause undet.
 DURATION 5 weeks plus

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results no autopsy
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE W. E. McMillan
M. E. McMillan, M. D. M. D. or other
 Address VAH, Fort Howard, Md. Date signed 1-21-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

01053

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County Baltimore
City or town Arbutus
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
1265 Maple Ave.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Arbutus
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1265 Maple Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME

Caroline Rebecca Kirschner

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife John Kirschner
6.(c) If alive, give age 79 years
7. Birth date of deceased (mo., day, yr.) 1870, December 18
8. AGE: Years 77 Months 0 Days 21 If less than one day — hrs. — min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home

FATHER 12. Name William Williams
13. Birthplace unknown
MOTHER 14. Maiden name unknown
15. Birthplace unknown

16. Informant husband - John Kirschner
Address 1265 Maple Ave - Arbutus

17. Burial Date thereof 10 JAN 48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Western Cemetery
Location Baltimore Road

18. Funeral director H. B. Herbert & Son
Address 1300 East Ave. Pl. 17

19. Jan 10 19 48 De Kieffer
Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 January 19 48 at 1030 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15 19 47 to January 8 19 48
and that I last saw him alive on January 8 19 48

Immediate cause of death Heart failure, acute
DURATION 1 mo.

Due to Coronary occlusion 1 day.

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —

When did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE William Goodman, M.D.
M. D. or other —

Address 1334 Sulphur Spring Road Date signed 8 January 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 12 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01054

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore - 19
 City or town Sparrow Point
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 36 yrs.
 Hospital, institution, or street address where death occurred:
2315 Ruth Ave.
 How long in hospital or institution? STANISLAWA

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State As in #1. County #1.
 City or town (If outside city or town limits, write RURAL and give nearest town)
 Street No. (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

STELLA JULIA KISIELEWSKI

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Alexander

7. Birth date of deceased (mo., day, yr.)

Kisielewski
April 19, 1890 -

6.(c) If alive, give age

58 years

8. AGE:

Years

Months

Days

If less than one day

57

9

6

hrs.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

MOTHER FATHER

12. Name

Frank Stachowski

13. Birthplace

Poland

14. Maiden name

Katherine Chester

15. Birthplace

Poland

16. Informant

Anna Lacey

Address

2425 Lincoln Ave. Balt. - 19 -

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Jan. 28-1948
(month) (day) (year)

Cemetery

Sacred Heart of Mary

Location

Baltimore County Md

18. Funeral director

George A. Weber

Address

705 S. Ann St

19. Date rec'd by registrar

January 26, 1948

A. W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25, 1948, at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 24, 1948, to Jan. 25, 1948, and that I last saw him alive on Jan. 25, 1948.

Immediate cause of death

Coronary Thrombosis 2 hours

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Louis M. Tallin, M.D.

M. D. or other

Address 608 North Point Rd. Baltimore - 19 - Md. Date signed 1/25/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 100 0105530
Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 monthsHospital, institution, or street address where death occurred:
Spring Grove State HospitalHow long in hospital or institution? 8 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balt. CityCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1702 Hollins St.
(If rural, give LOCATION)2.(a) If veteran, name war —

3.(a) FULL NAME

Paul Kolosis

3.(b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed6.(b) Name of husband or wife unknownOctober 10, 1882 6.(c) If alive, give age deceased years7. Birth date of deceased (mo., day, yr.) October 10, 18828. AGE: Years 65 Months 3 Days 7 It less than one day — hrs. — min.9. Birthplace Yugoslavia
(Town, county, and state)10. Usual occupation laborer11. Industry or business —12. Name Paul Kolosis13. Birthplace Yugoslavia14. Maiden name Maria15. Birthplace Yugoslavia16. Informant Mrs. Jennie Bookland (friend)Address 1702 Hollins St.17. Burial Date there Jan 26, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium St. OlivesLocation Baltimore Md18. Funeral director Robert C. B. M. WaltersAddress 1702 Hollins St.19. 1/12 19 48 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1948 at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 23, 1947 to January 17, 1948and that I last saw him alive on January 16, 1948Immediate cause of death Acute Myocardial failure DURATION 1 hr.Due to Chronic Myocardial Heart Disease yearsDue to Generalized Arteriosclerosis yearsOther conditions —

(Include pregnancy within 8 months of death)

Major findings of operations — Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE J. W. Hedrick M. D. or otherAddress — Date signed —

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01058

1. PLACE OF DEATH:

County Harford
City or town Phoenix
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? ☒

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore
City or town Phoenix Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

NICHOLAS S WACEY.

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Lusay Bradley.

7. Birth date of deceased (mo., day, yr.) Jan 21. 1866

8. AGE: Years 82 Months 10 Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace Retail Farmer
(Town, county, and state)

10. Usual occupation John Wacey.

11. Industry or business Ireland.

12. Name Mary Smith.

13. Birthplace Ireland.

14. Maiden name _____

15. Birthplace _____

16. Informant Miss Mary Martin

Address Phoenix

17. Burial, cremation, or removal (which?) Burial Date thereof Feb. 11. 48
(month) (day) (year)

Cemetery or crematory St. John's

Location Phoenix

18. Funeral director C. E. Arthur

Address Phoenix, Md.

19. Feb. 2 1948 C. E. Arthur Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30, 1948 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 30, 1948 to 19 and that I last saw him alive on 19

Immediate cause of death Coronary Thrombosis DURATION 1/2h.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ injured at work? _____

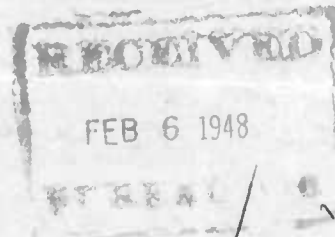
Signature Clifford F. Hudson M.D. M. D. or other _____

Address Phoenix Md. Date signed 1/31/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diet. No. 40

1. PLACE OF DEATH:

County Baltimore
City or town GLEN ARM, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **
Hospital, institution, or street address where death occurred: --
How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County ---
City or town GLEN ARM, MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No. **
(If rural, give LOCATION)
2(a) If veteran, name war No

3. (a) FULL NAME

Edgar A. LAWS

3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married
8. (b) Name of husband or wife Harriet Oakley Laws
7. Birth date of deceased (mo., day, yr.) Oct. 1, 1864
8. AGE: Years 83 Months 3 Days 10 It less than one day --- hrs. --- min.

9. Birthplace Windsor, Nova Scotia
(Town, county, and state)
10. Usual occupation None
11. Industry or business --

12. Name John Laws
13. Birthplace Rodden, Nova Scotia
14. Maiden name Elizabeth Corkum
15. Birthplace Chester, Nova Scotia

16. Informant Mrs. Harriet O. Laws
Address Glen Arm, Md.

17. Cremation Date thereof 1/14/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
XXXX Loudon Park Crematory
Cemetery or crematory Baltimore, Md.
Location

18. Funeral director WM. J. TICKNER & SONS INC.
Address North & Pa. Aves., Balto, Md.

19. 1/13 18 A. W. Hedrick
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11, 1948 at 6 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8 1948 to Jan 11 1948
and that I last saw him alive on Jan 8 1948

Immediate cause of death Carcinoma of prostate gland
DURATION 3 yrs.

Due to ---
Due to ---
Other conditions ---
(Include pregnancy within 3 months of death)

Major findings of operations --- Date of op. ---
Autopsy results ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide --- Date of ---
Where did injury occur? --- (City or town) --- (County) --- (State)
Injured at home, farm, industry, pub'c place (where?) ---
Means of injury --- Injured at work? ---

Signature Clifford F. Hudson, M.D. M. D. or other ---
Address Fork, Md. Date signed 1/14/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01058

Reg. Diat. No. 35

1. PLACE OF DEATH:

County Balto.
 City or town monkton, md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 weeks 5 days
 Hospital, institution, or street address where death occurred:
monkton, md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md. County Carroll
 City or town Westminister, md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Beverly Scarlett Lee

3. (b) Social Security Number

4. Sex F 5. Color or race colored 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____ 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 19478. AGE: Years _____ Months _____ Day 22 It less than one day _____ hrs. _____ min.9. Birthplace Westminister, md.
(Town, county, and state)10. Usual occupation none

11. Industry or business _____

FATHER 12. Name Frederick Lee
13. Birthplace Phoenix, md.MOTHER 14. Maiden name Martha Jones
15. Birthplace monkton, md.16. Informant Frederick Lee
Address Westminister, md.17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 1/20/48
(month) (day) (year)Cemetery or crematory mt Zion
Location Long Green, md.18. Funeral director William J. Chatman Jr
Address 1701 Mc Culloch St. Balto, md.19. 1/19 48 A. W. Hedrick
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 18 1948 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____ and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Strangled from asphyxiation
3 weeks
Due to _____Due to _____
Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ACCIDENT Date of 1/18/48
Where did injury occur? MONKTON BALTO MD
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Home
Means of injury _____ Injured at work?23. SIGNATURE P. H. France M. D. another
Address Parleton, md. Date signed 1/18/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01059

Reg. Dist. No. 43

1. PLACE OF DEATH:

County... **Baltimore**
City or town... **Raspeburg, Md.**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **21 years**
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... **Maryland** County... **Baltimore**
City or town... **Raspeburg, Md.**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **7410 Kenleigh Ave.,**
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME

Andrew Lewis

3. (b) Social Security Number

4. Sex **male** 5. Color or race **white** 6. (a) Single, married, widowed, or divorced **married**

6. (b) Name of husband or wife **Dorothea M. Lewis**

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **March 22nd, 1863**

8. AGE: Years **84** Months **9** Days **12** If less than one day hrs. min.

9. Birthplace **Maryland**
(Town, county, and state)

10. Usual occupation **Retired U.S. Instructor**

11. Industry or business **Naval Academy**

12. Name **Fred Lewis**

13. Birthplace **Unknown**

14. Maiden name **Magdalena Thamet**

15. Birthplace **Maryland**

16. Informant **Mrs. Frederick Robler**

Address **7410 Kenleigh Ave.,**

17. **burial** Date thereof (month) (day) (year)

Cemetery or crematory **Mount Carmel**
Baltimore, Md.

Location **Lassahn Funeral Home**

18. Funeral director **7401 Belair Road**

19. **Jan 11** 19 **47** **Mr. A. T. Ruffin** Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH **Jan 4** 19 **48** at **11 A** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Dec 25** 19 **47** to **Jan 4** 19 **48**
and that I last saw him alive on **Jan 3** 19 **48**

Immediate cause of death **Coronary Thrombosis** DURATION **Sudden**

Due to **Arterio Sclerotic Cardiovascular renal disease** **2 yrs**

Due to **Gross Hematuria due to probable Carcinoma Rt Kidney** **2 yrs**
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE **W. M. Baumgardner** M. D. or other
Address **Balto 5 Md** Date signed **1/4/48**

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 10 1948

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Rural - Baltimore
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1625 Dartford Rd. - 21

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore
 City or town Rural Baltimore
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1625 Dartford Rd. - 21
 (If rural, give LOCATION)

2. (a) If veteran, name war no

3. (a) FULL NAME

JAMES HARRY LINDEMORE

3. (b) Social Security Number

215-09-2152

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Ada L. (Sowers) Lindemore6. (c) If alive, give age 55 years7. Birth date of deceased (mo., day, yr.) April 28, 1891

8. AGE: Years 53 Months 8 Days 13 If less than one day
 hrs. min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Retired - 5 yrs.11. Industry or business Simpson & Doeller12. Name James W. Lindemore13. Birthplace Maryland14. Maiden name Ida Mae Corns15. Birthplace Maryland16. Informant James H. Lindemore, Jr. - sonAddress 1625 Dartford Rd. - 21Burial 1/13/48

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Parkwood cemeteryLocation Baltimore, Maryland

HENRY SANDER & SONS, INC.

18. Funeral director NORTH AVE. & BROADWAY

Address

19. Jan 13 19 48 R. W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 19 48 at 8.30A M

CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 43 to before date 19 48

and that I last saw him alive on Jan 5 19 48

Immediate cause of death Ischemic heart disease DURATION 2 mos

Due to hypertension

Due to Return of cerebral blood flow

Other conditions Chronic Renal Failure

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Gians

Address 612 W. 40 St. N. N. D. D. Date signed 1/10/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01061

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Maryland
 How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Baltimore 22
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6 Avon Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW-II

3. (a) FULL NAME

CLAY LISK

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife single
 7. Birth date of deceased (mo., day, yr.) September 30, 1897 6. (c) If alive, give age _____ years
 8. AGE: Years 50 Months 3 Days 16 If less than one day _____ hrs. _____ min.

9. Birthplace Troy, North Carolina
 (Town, county, and state)
 10. Usual occupation Unemployed
 11. Industry or business _____

12. Name Robert E. Lisk
 13. Birthplace Troy, N.C.
 14. Maiden name Betty McDonald
 15. Birthplace Troy, N.C.

16. Informant Clinical Records, Vets. Adm. Hosp.
Fort Howard, Maryland
 Address _____

17. Burial Date thereof 1-17-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baltimore National Cemetery
 Location 5501 Frederick Ave. Balto. Md.

18. Funeral director Roland Fisher
 Address 2112 Dundalk Ave. Balto. Md.

19. Jan 19 - 1948 Sharon L. Harber
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 19 48 10:55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5 19 48 to January 16 19 48
 and that I last saw him alive on January 16 19 48

Immediate cause of death _____ DURATION
Tuberculosis, pulmonary, bilateral, 33 mos.
far advanced, active plus

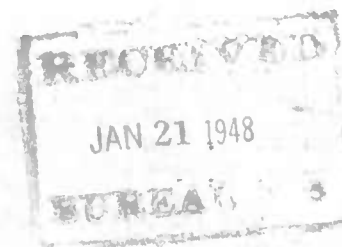
Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations none
 Date of op. _____
 Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE JACK MORROW M. D. or other
 Address VAH FT. Howard, Md. Date signed 1-17-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01062

1. PLACE OF DEATH:

County Baltimore
City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

BERTHA IRENE LUTZ

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Albert Lutz
6. (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July 27, 1888

8. AGE: Years 59 Months 5 Days 28 If less than one day
.....hrs.min.

9. Birthplace Carroll County, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name George Stearns

13. Birthplace Carroll County, Md.

14. Maiden name Ida May Poole

15. Birthplace Carroll County

16. Informant Albert Lutz

Address Owings Mills, Md.

17. Burial (Burial, cremation, or removal. Which?) Jan. 28, 1948
(month) (day) (year)

Cemetery or crematory Taylorville Cem.

Location Taylorville, Carroll County

18. Funeral director Wm Berryman & Sons

Address Reisterstown, Maryland

19. 1/27/48 (Date rec'd by registrar) Dr. E. E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25, 1948 at 8:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from For about two years to Jan. 25, 1948

and that I last saw her alive on Jan. 20, 1948

Immediate cause of death

Coronary Thrombosis

Due to

Chronic Myocarditis

Due to

Arterial Hypertension

Other conditions

None
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE E. E. Nichols MD M. D. or other

Address Pelhamville Md Date signed 1-27-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 28 1948
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

01063

1. PLACE OF DEATH:

County Baltimore

City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1902 Maxwell Ave.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Amelia E. Madl

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced W

6. (b) Name of husband or wife Ludwig

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1869

8. AGE: Years 78 Months 6 Days 5 If less than one day
.....hrs.min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name Balthazer Beyer

13. Birthplace Germany

14. Maiden name Anna G. Hoch

15. Birthplace Germany

16. Informant Mrs. Catherine Ziegler

Address 1904 Maxwell Ave.

17. Burial Date thereof 1/12/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Lawn

Location 7225 Eastern Ave.

18. Funeral director Clarence F. Hoffmann

Address 1639 Broadway

19. Jan 12 1948 R. W. Hoffmann
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 19 48, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1 19 47, to Jan 9 19 48
and that I last saw him alive on Jan 9 19 48

Immediate cause of death Coronary
stagnation

DURATION

5 min

Due to

Due to

Other conditions Myocardial Degeneration

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. A. Brown M. D. or other

Address Liberty Park Date signed 1-10-48

MARGIN RESERVED FOR BINDING

I

9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The content age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:

County BaltimoreCity or town Raspeburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

6601A Kenwood Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Raspeburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6601A Kenwood Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JOHN A. MAGSAMEN

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Louise M. Magsamen

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 23, 18848. AGE: Years Months Days It less than one day
63 11 22 hrs. min.9. Birthplace Balto. Co., Md.
(Town, county, and state)10. Usual occupation Truck Farmer

11. Industry or business

12. Name Charles Magsamen13. Birthplace Unknown14. Maiden name Fredericka Miller15. Birthplace Germany16. Informant Mrs. John A. MagsamenAddress 6601A Kenwood Ave., Balto. 6, Md.17. burial Date thereof Jan. 18, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Zion LutheranLocation Stemmers Run, Md.18. Funeral director Raspeburg Funeral HomeAddress 7401 Belair Road19. 1-17 19 48 A.W. Krikel
(Date rec'd by registrar) AMS Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15th, 19 48, at 2:35 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10, 1947 to Jan 15, 1948 and that last saw him alive on Jan 14, 1948

Immediate cause of death

DURATION

Hodgkins Disease8 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph P. Korny M.D.Address 2206 E Madison St Date signed 1/16/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:

County Baltimore
 City or town Rural - Monkton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Rural - Monkton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Monkton Road
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Martin

3. (b) Social Security Number

168-12-1588

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

B. (b) Name of husband or wife

Millie Phipps Martin

7. Birth date of deceased (mo., day, yr.)

January 6 19016. (c) If alive, give age 47 years

8. AGE:

Years

47

Months

Days

17

If less than one day

hrs.

min.

9. Birthplace

West Jefferson County, N. Carolina
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Fair View Farm, Monkton Md.

MOTHER FATHER

12. Name

Miles Martin

13. Birthplace

North Carolina

14. Maiden name

Minnie ? Unknown

15. Birthplace

? Unknown

16. Informant

Millie P. Martin

Address

Monkton, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 1/27/48

(month) (day) (year)

Cemetery or crematory

Oxford, Pa.

Location

Oxford, Pa.

18. Funeral director

Geo. H. Nelson

Address

1303 Presstman St.

19. Jan. 26

(Date rec'd by registrar)

19 48

R. W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

23 January19 48

at

12:00 ^{mid} _{night} ^M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June19 47

to

January 19 48

and that I last saw him alive on

9 June19 47

Immediate cause of death

Myocardial Infarction

DURATION

15 hours

Due to

Coronary Occlusion

Due to

Cardio-vascular disease

Other conditions

Arthritis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Medical Examiner R. C. Hudson consulted.

23. SIGNATURE

Walter T. Keeson, D.

M. D. or other

Address

Cockeysville Md.

Date signed

1-24-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00218

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.City or town Sparrow Point
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Pipe Mill.

How long in hospital or institution?

3. (a) FULL NAME

George McClain, (McCLAIN)

3. (b) Social Security Number

4. Sex

Male

5. Color or race

wh.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Della McClain

7. Birth date of deceased (mo., day, yr.)

1911

8. AGE:

37

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Raleigh N. C.
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Bethlehem Steel Corp.

12. Name

unknown

13. Birthplace

unknown

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

Della McClain

Address

1015 Lamont Ave

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof

1/30/48
(month) (day) (year)

Cemetery or crematory

mt. Calvary

Location

Brooklyn, mt.

18. Funeral director

Elroy O. Wilson

Address

1000 Brantly Ave.

19.

(Date rec'd by registrar)

1/28/48
A. W. Hedrick
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Baltimore 5.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

1015 Lamont Ave
(If rural, give LOCATION)

2. (a) If veteran, name war

✓

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 26 1948 at 7:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw h... alive on

19...

Immediate cause of death

Coronary occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Dr. J. M. Harrison, M.D.
Deputy Medical Examiner
Baltimore Co. Health Dept.
1/26/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

458

00219

Reg. Dist. No. 42

1. PLACE OF DEATH:

County Balto.City or town Halethorpe 4510 Maple Ave.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Halethorpe
(If outside city or town limits, write RURAL and give nearest town)Street No. 4510 Maple Ave.
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

MARY CATHERINE MC CLOSKEY

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife James C. McCloskey

7. Birth date of deceased (mo., day, yr.)

May 31, 1868

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

79

7

1

hrs.

min.

9. Birthplace Baltimore
(Town, county, and state)10. Usual occupation Home

11. Industry or business

12. Name AGUSTAS Litsinger13. Birthplace Balto.14. Maiden name Margaret Fishpaw15. Birthplace Md.16. Informant Mr. W. B. McCloskeyAddress 1706 Lincoln Drive 2717. Burial Date thereof 1/5/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or place of interment Loudon Pk.Location Balto. Md.18. Funeral director WM. J. TICKNER & SONS INC.Address North & Pa. Aves. Balto. 17, Md.19. 1/5 19 48 A.W. Hedrick
(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2, 1948 at 1 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1947 to Jan 2 1948and that I last saw him alive on Jan 2 1948Immediate cause of death Carcinoma of Tongue

DURATION

3 1/2 yrsDue to MyocardialDue to for suffering 2 hrsOther conditions Senility 5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of tongueDate of op. ?

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE W. B. McCloskey M. D. or otherAddress Elkridge Md Date signed 4/3/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Md Baltimore
 City or town Sharrow Point
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County
 City or town Sharrow Point
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1102 H St
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

John A McMillan

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Sarah Q. Jackson
 7. Birth date of deceased (mo., day, yr.) Dec 23, 1882 8. (c) If alive, give age years
 8. AGE: Years 66 Months Days 10 If less than one day hrs. min.

9. Birthplace Johnstown Pa.
 (Town, county, and state)
 10. Usual occupation Melting
 11. Industry or business Beth. Steel Corp.
 12. Name McMillan
 13. Birthplace Pa
 14. Maiden name Angelina Rager
 15. Birthplace Pa

16. Informant Sarah Q. McMillan
 Address 1102 H. St
 17. Removal Date thereof 1-2-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Beushoff Hill
 Location Johnstown Pa
 18. Funeral director John G. Moran
 Address 3000 E Baltimore St
 19. Jan 2, 1948 Lewman T. Harris
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1, 1948 at M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 29, 1947 to Jan 1, 1948
 and that I last saw him alive on Jan 1, 1948

Immediate cause of death Cerebral hemorrhage

DURATION
5 days

Due to Cerebral hemorrhage
 Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Dr. W. D. ... M. D. or other
 Address 521 D St. SPring Date signed 1-2-48

RECEIVED
JAN 6 1948
B. HEAD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00221

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Balta.
City or town Catonville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mo
Hospital, institution, or street address where death occurred:
Opitz Commercial Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Brunswick
(If outside city or town limits, write RURAL and give nearest town)
Street No. West Palm St.
(If rural, give LOCATION)
2. (a) If veteran, name war.

3. (a) FULL NAME

John W. Moore

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Mary E. Brantner

7. Birth date of deceased (mo., day, yr.) Feb. 18 1861 6. (c) If alive, give age _____ years

8. AGE: 86 Years Months Days If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Retired B. & O. R.R.

11. Industry or business Shops

FATHER 12. Name Thomas Moore

13. Birthplace West Virginia

MOTHER 14. Maiden name Mary Meyers

15. Birthplace Penn.

16. Informant J. Williams Moore

Address Baltimore Md.

17. Burial (Burial, cremation, or removal) Which? Burial Date thereof Jan 14 1948

Cemetery or crematory Green Hill

Location Martinsburg W. Va.

18. Funeral director C. H. Felt & Bros

Address Brunswick Md.

19. 1-13 1948 V. E. Hays Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1948 at 12 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 1948 to Dec 12 1948 and that I last saw him alive on Jan 11 1948

Immediate cause of death Chr. Myocarditis DURATION 1 mon

Due to arterio Sclerosis
Coronary Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H. Hays

M. D. or other Colonel

Address Colonel Date signed 1-13-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 15 1948

ETEE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: County <u>Baltimore</u> City or town <u>Woodbrook</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>30 yrs. ?</u> How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Md</u> County <u>Baltimore</u> City or town <u>Woodbrook P.O. #12</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Montrose Rd</u> (If rural, give LOCATION) 2. (a) If veteran, name war			
3. (a) FULL NAME <u>Harry Morrison</u>				3. (b) Social Security Number			
4. Sex <u>Ms.</u>		5. Color or race <u>W.</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>			
6. (b) Name of husband or wife <u>Mary Watters</u>				6. (c) If alive, give age <u>71</u> years			
7. Birth date of deceased (mo., day, yr.) <u>May 1 1875</u>				8. AGE: Years <u>72</u> Months <u>8</u> Days <u>25</u> If less than one day hrs. min.			
9. Birthplace <u>Balto. Md</u> (Town, county, and state)				10. Usual occupation <u>Retired</u>			
11. Industry or business				12. Name <u>Dr. James Morrison</u>			
13. Birthplace <u>Md</u>				14. Maiden name <u>Laura Startzman</u>			
15. Birthplace <u>Md</u>				16. Informant <u>Mrs. Mary W. Morrison</u> Address <u>Woodbrook P.O. #12</u>			
17. (Burial, cremation, or removal, Which?) <u>Burial</u> Date thereof <u>Jan 28 1948</u> (month) (day) (year) Cemetery or crematory <u>Green Mount</u> Location <u>Balto. Md</u>				18. Funeral director <u>Benny W. Jenkins - Smo</u> Address <u>McCullon Orchard St</u>			
19. (Data rec'd by registrar) <u>Jan 27 1948</u> <u>R. W. Hynd</u> Registrar				20. DATE OF DEATH <u>Jan 26th</u> 19 <u>48</u> at <u>26</u> M			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Sept. 1st 1947</u> to <u>Jan 26th 1948</u> and that I last saw him alive on <u>Jan 25th 1948</u>				IMMEDIATE CAUSE OF DEATH <u>Pulmonary edema</u> <u>Myocardial infarction</u> Due to <u>Coronary Arteriosclerosis</u> Due to Other conditions <u>h</u> (Include pregnancy within 8 months of death)			
Major findings of operations				Autopsy results <u>h</u> PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide. Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?				23. SIGNATURE <u>J. H. Chatard</u> M. D. or other Address <u>1300 N. Calvert St</u> Date signed <u>Jan 28/48</u>			

Dr J Albert Chatard
1300 N Calvert St

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Owings Mills
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 23 yrs
 Hospital, institution, or street address where death occurred:
Academy Ave Owings Mills
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Md County..... Baltimore
 City or town..... Owings Mills
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Academy Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... No

3. (a) FULL NAME

Belle Eby Moser

3. (b) Social Security Number

None

4. Sex..... F 5. Color or race..... W 6. (a) Single, married, widowed, or divorced..... W

8. (b) Name of husband or wife..... Charles David Moser

7. Birth date of deceased (mo., day, yr.)..... January 23 1866
 8. (c) If alive, give age..... years

8. AGE: Years..... 82 Months..... - Days..... 7 If less than one day..... hrs. min.

9. Birthplace..... Frederick Co Md
(Town, county, and state)10. Usual occupation..... Housewife11. Industry or business..... -12. Name..... Lemuel Eby13. Birthplace..... Frederick Co Md14. Maiden name..... Martha Six15. Birthplace..... Frederick Co Md16. Informant..... Roy MoserAddress..... Gwynnbrook Ave Owings Mills Md

17. Burial..... Data thereof..... Feb 2 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Druid Ridge CemeteryLocation..... Pikesville Md18. Funeral director..... Wm Berryman & SonsAddress..... Reisterstown Md

19. 1-31-1948 Mary B. Eline
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 1-30-48 19..... at..... 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 1-1-1930 to..... 1-30-48
 and that I last saw him alive on..... 1-29-48 19.....

Immediate cause of death..... Cerebral hemorrhage DURATION..... 1 yr

Due to..... hypertension

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Mary B. Eline M. D. or other

Address..... Reisterstown Md Date signed..... 1-31-48

RECEIVED

- FEB 2 1948

BT 824

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: *Balto.*
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
 George Washington Newton Sr.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Annie M.
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) July 15, 1862
 8. AGE: Years 85 Months 5 Days 23 If less than one day..... hrs. min.

9. Birthplace..... Butts County, Georgia
 (Town, county, and state)
 10. Usual occupation..... Retired Jurist
 11. Industry or business.....
 12. Name..... Ezekiel Parks Newton
 13. Birthplace..... Unknown
 14. Maiden name..... Nancy Webb
 15. Birthplace..... Unknown

16. Informant..... Douglas Newton
 Address..... 325 Dixie Drive -- Towson, Md.
 17. Removal..... Date thereof..... Jan. 9, 1948
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory..... Forsyth Cemetery
 Location..... Forsyth, Georgia
 18. Funeral director..... William Cook, Inc.
 Address..... 1217 St. Paul Street

19. Jan. 8, 1948
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 1/8 1948 at 9:55 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/3 1948, to 1/8 1948, and that I last saw him alive on 1/7 1948.

Immediate cause of death..... Respiratory Failure DURATION 3 Days
 Due to..... Myocardial Failure 6 Months
 Due to..... Cerebral Vascular Disease 10 yrs
 Other conditions..... Probably cause of large vessel
 (Include pregnancy within 3 months of death)
 Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?
 23. SIGNATURE..... Chas. P. O'Donnell M.D. or other
 Address..... 7301 York Rd. Date signed..... 1/8/48

RECEIVED
JAN 9 1948
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information only. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00225

Reg. Dist. No.

30

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Catonsville 28, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 7 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution?..... 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 2041 E. North Avenue
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

William Nicoll (WILLIAM DONNELD NICOLL)

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Edith Nicoll

7. Birth date of deceased (mo., day, yr.)

October 27, 1894

6.(c) If alive, give age.....?..... years

8. AGE:

Years

Months

Days

If less than one day

53220

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Paper hanger

11. Industry or business

Interior decoration

MOTHER FATHER

12. Name

Wm. D. Nicoll

13. Birthplace

Pennsylvania

14. Maiden name

Grace Sappington

15. Birthplace

Maryland

16. Informant

Hospital Records

Address

Catonsville 28, Maryland

17. Burial

Date thereof..... 1/19/48

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Mount Olivet

Location

Baltimore, Md.

18. Funeral director

HENRY SANDER & SONS, INC.

Address

NORTH AVE. & BROADWAY

19.

1/19
(Date rec'd by registrar)

19.

x PR. W. HedrickDMRegistrarDMRegistrarDMRegistrarDMRegistrarDMRegistrarDMRegistrarDMRegistrarDMRegistrarDMRegistrarDMRegistrarDMRegistrarDMRegistrarDMRegistrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 16,..... 19 48, at 12:35 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 10,..... 19 48, to January 16, 19 48and that I last saw him alive on..... January 16,..... 19 48

Immediate cause of death

Bilateral lobar pneumonia --

Undetermined

AgranulocytosisToxic Origin

Due to.....

Other conditions..... Toxic delirium

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.....

Autopsy results..... As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE

Isadore Tuerk, M. D.

M. D. or other

Address..... Catonsville 28, Md. Date signed..... 1/16/48

DURATION

33 hrs.indef.7 days

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 58

00226

94a

38

1. PLACE OF DEATH: Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)	
County: Baltimore		State: Md.	
City or town: Ruxton		County: Balto.	
(If outside city or town limits, write RURAL and give nearest town)		City or town: Ruxton-4	
(If outside city or town limits, write RURAL and give nearest town)		Street No: Circle Rd.	
(If rural, give LOCATION)		2(a) If veteran, name war: No	
3. (a) FULL NAME: HARRY LOUIS NORRIS SR.		3. (b) Social Security Number: No	
MEDICAL CERTIFICATION			
4. Sex: M		5. Color or race: W	
6. (a) Single, married, widowed, or divorced: Married		20. DATE OF DEATH: Jan. 14, 1948	
6. (b) Name of husband or wife: Elizebeth S.		21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1945 to Jan 14, 1948	
7. Birth date of deceased (mo., day, yr.): Oct. 8, 1884		and that I last saw him alive on: 12/19/47	
8. AGE: Years: 63		Immediate cause of death: acute coronary thrombosis	
Months: 3		coronary artery atherosclerosis	
Days: 6		DURATION: 15 min.	
If less than one day: hrs. min.		Due to: ...	
9. Birthplace: Baltimore, Md.		Due to: ...	
(Town, county, and state)		Other conditions: ...	
10. Usual occupation: Owner		(Include pregnancy within 3 months of death)	
11. Industry or business: Norris Milk Products		Major findings of operations: ...	
12. Name: Louis F. Norris		Autopsy results: ...	
13. Birthplace: Baltimore, Md.		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
14. Maiden name: Lavina Jones		22. VIOLENCE: If death was due to external causes, fill in the following:	
15. Birthplace: Harford County, Md.		Accident, suicide, or homicide: ...	
16. Informant: Elizebeth S. Norris		Where did injury occur? ...	
Address: Circle Rd., Ruxton, Md.		Injured at home, farm, industry, public place (where?) ...	
17. Burial: Loudon Park		Means of injury: ...	
(Burial, cremation, or removal. Which?)		Injured at work? ...	
Date thereof: 1/16/48		23. SIGNATURE: ...	
Cemetery or crematory: Baltimore, Md.		Address: 2320 Euterpe St.	
18. Funeral director: WM. J. TINKNER & SONS INC.		M. D. or other: ...	
Address: North & Pa. Aves; Balto., Md.		Date signed: 1/14/48	
19. 1-16 48		Registrar: ...	
(Date rec'd by registrar)		Address: ...	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information truthfully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 002370

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 months 28 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 7 months 28 days

3. (a) FULL NAME

Anna Elizabeth OTT4. Sex female5. Color or race W6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov 9th 18678. AGE: Years 80 Months 2 Days 22 If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state) housewife

10. Usual occupation

11. Industry or business

12. Name George Washington OTT13. Birthplace Md.14. Maiden name Anna Clemens15. Birthplace Md.16. Informant Hospital records

Address _____

17. Removal Date thereof 2/2/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory LewisstownLocation Penna18. Funeral director William Cook Inc.Address 1217 St. Paul St

2-1 48 City Health Dept

19. (Date rec'd by registrar) 2-1 48 Registrar 2-1 48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residences of mother)

State Md County _____City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. Church Home Hospital

(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31st 19 48 at 2¹⁵ A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3rd 19 47 to January 31st 19 48and that I last saw her alive on Jan. 30 19 48Immediate cause of death Acute myocardial failureDue to Coronary Arterio-sclerosisOther conditions Pulmonary infarctPulmonary thrombosis

(Include pregnancy within 6 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE _____

Address _____

M. D. or other _____

Date signed 1/31/48

RECEIVED
FEB 2 1943
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... BaltimoreCity or town..... Relay
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

4900 Cedar Ave.

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... BaltimoreCity or town..... Relay
(If outside city or town limits, write RURAL and give nearest town)Street No..... 4900 Cedar Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

(James W.) William H. Parks

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife..... Mary R. Parks7. Birth date of deceased (mo., day, yr.) July 24, 1881

6.(c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
66 07 5 24 hrs. min.9. Birthplace..... Baltimore County, Md.
(Town, county, and state)10. Usual occupation..... Retired Ice Dealer

11. Industry or business

12. Name..... James Parks13. Birthplace..... Baltimore County, Md.14. Maiden name..... Annie Morris15. Birthplace..... Ireland16. Informant..... Mrs. Annie BrownAddress 4900 Cedar Ave.17. Burial Date thereof..... Jan. 22, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Loudon Park CemeteryLocation..... Baltimore, Md.18. Funeral director..... Wills LamoreanAddress 4510 Liberty Heights Ave.19. 1/20/48 19..... a. v. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 18 1948 at 11.59P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 9 1948 to Jan 18 1948
and that I last saw him alive on Jan 18 1948Immediate cause of death..... Right Cerebral Hemorrhage

DURATION

Due to.....

Due to.....

Other conditions..... Ch. Myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... George E. Shuman MD

M. D. or other

Address..... Medical Arts Bldg. Date signed..... 1/19/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00229

Reg. Dist. No. 37

1. PLACE OF DEATH
 County Baltimore
 City or town Rockyville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Rockyville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. York Road
 (If farm, give LOCATION)
 2. (a) If veteran, name war World War II

3. (a) FULL NAME Richard Charles Paul

3. (b) Social Security Number

554-34-2091

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced
 6. (b) Name of husband or wife Elmer (nee Brown)
 7. Birth date of deceased (mo., day, yr.) May 30, 1921 6. (c) If alive, give age years
 8. AGE: Years 26 Months 7 Days 6 It less than one day hrs. min.

9. Birthplace Hartford, Conn.
 (City, county, and state)
 10. Usual occupation Electrician
 11. Industry or business Self employed
 12. Name Charles E. Paul
 13. Birthplace Islip, Long Island, N.Y.
 14. Maiden name Evelyn L. Arnlin
 15. Birthplace Hartford, Conn.

16. Informant Evelyn Brown
 Address 229 Murdoch Rd, Balto.
 17. Burial (Burial, cremation, or removal, Which?) Date thereof Jan 8, 1948
 (month) (day) (year)
 Cemetery or crematory Gersops
 Location Sparks, Md.
 18. Funeral director Landen M. Brooks
 Address Sparks, Md.
 19. Jan 7 19 48 MC Euse
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 19 48 at 12 A. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19 48 to 19 19 48
 and that I last saw him None 19 48

Immediate cause of death Gas poisoning; Suicide DURATION 1 1/2 19 48

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

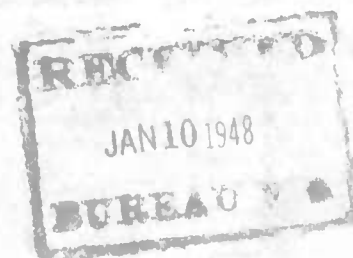
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide suicide Date of 1/6/48Where did injury occur? Rockyville Balto 1/6/48
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Gas poisoning; suicide Injured at work? No23. SIGNATURE Alvin G. Hudson M.D. D.M.E. M. D. or otherAddress Towson Md Date signed 1/6/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

00230

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County BaltimoreCity or town Granite
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Granite
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary A. Beach

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age _____ years

1868

8. AGE:

Years

Months

Days

If less than one day

80

hrs. min.

9. Birthplace

Baltimore Md.
(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 1/10/48

(Date rec'd by registrar)

1948

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Jan - 9

19

48 at 7⁴⁵ PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 4, 1948 to Jan 9, 1948and that I last saw him alive on Jan 8, 1948

Immediate cause of death

Peritonitis

DURATION

Due to

Strangulated hernia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thos. E. Martin
Randalltown

M. D. or other

Date signed 1/10/48

RECEIVED
FEB 2 1948
66 664

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00231

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH

County BaltimoreCity or town Relay
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 yrs

Hospital, institution, or street address where death occurred:

5173 Vinodustone

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltimoreCity or town Relay
(If outside city or town limits, write RURAL and give nearest town)Street No. 5173 Vinodustone
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Margaret Evelyn Pennell

3. (b) Social Security Number

none4. Sex Female 5. Color of race white 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Charles H. Pennell6. (c) If alive, give age 5 years7. Birth date of deceased (mo., day, yr.) Nov 24 19638. AGE: Years 84 Months 2 Days 5 If less than one day9. Birthplace Marshallburg W. Va
(Town, county, and state)10. Usual occupation Domestic11. Industry or business None12. Name Jacob Kenna13. Birthplace Piedmont W. Va14. Maiden name Emily Sowers15. Birthplace Piedmont W. Va.16. Informant Andrew L. Pennell (son)Address 5173 Vinodustone Relay Md17. (Burial, cremation, or removal. Which?) B. Date thereof 1-23-48
(month) (day) (year)Cemetery or crematory London ParkLocation 3801 Fitchburg Ave18. Funeral director James L. McCueleyAddress 1301 J. Fort Ave.19. 1/30 19 48 R. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1948 at 3:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1945 to Jan 29 1948and that I last saw him alive on Jan 29 1948Immediate cause of death Myocardial infarction DURATION 6 hrsDue to Diabetes 18 yrsDue to General arteriosclerosis 15 yrsOther conditions Senility 2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. W. Hedrick M.D. or otherAddress Elbridge Md Date signed 1/29/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County.....

City or town..... Caltonville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

16 Fusting Ave. House in the Pines

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County.....City or town..... Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No..... 1515 Mt. Royal Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

JOSEPH E. PERKINS SR.

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife..... Faye B.

7. Birth date of deceased (mo., day, yr.)

April 9, 1971

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

76105

hrs.

min.

9. Birthplace..... Boston, Mass.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

Steam engineer

MOTHER FATHER

12. Name.....

Joseph O. Perkins

13. Birthplace

Dorchester, Mass.

14. Maiden name.....

Alfreda Eliza

15. Birthplace

M. Edgecombe Me

16. Informant.....

Mrs. Faye B. Perkins

Address

1515 Mt. Royal Ave

17.

Burial

Date thereof.....

1/17/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... XXXX Lorraine Cem.Location..... Baltimore, Md.18. Funeral director..... WM. J. TICKNER & SONS INC.Address..... North & Pa. Aves; Balto., Md.

19.

(Date rec'd by registrar)

19.

48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan. 14, 1948 19..... at..... 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 15 19..... 47 to..... Jan 14 19..... 4 Pand that I last saw him alive on..... Jan 14 19..... 4 P

Immediate cause of death.....

Bronchiogenic carcinoma

DURATION

5 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Stephen J. Van Lellie M.D.

M.D. or other

Address..... 2843 St Paul St Date signed 1-15-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information equally. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00333

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Spring Grove State Hospital
 Hospital, institution, or street address where death occurred:
7 years; 2 months; 18 days
 How long in hospital or institution? 7 years, 2 months, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1124 Scott Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

John J. Peters

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Josephine
 7. Birth date of deceased (mo., day, yr.) August 2, 1878
 6. (c) If alive, give age _____ years
 8. AGE: Years 69 Months 5 Days 16 Less than one day _____ hrs. _____ min.
 9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Footway Inspector
 11. Industry or business Municipal Civil Service
 12. Name George Peters
 13. Birthplace Maryland
 14. Maiden name Helen Kelly
 15. Birthplace Maryland

16. Informant Hospital Records
 Address Catonsville, 28, Maryland
 17. Burial Date thereof 1/22/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory New Cathedral Cem
 Location 4300 Old Frederick Rd
 18. Funeral director John J. Brown & Son
 Address 901-03 Hollins St.
 19. Jan. 19, 48 H. W. Adrich
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 19 48 at 8:30 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 1 19 40 to January 18 19 48
 and that I last saw him alive on January 18 19 48
 Immediate cause of death Cachexia

DURATION

6 weeks

Due to Arteriosclerotic Heart Disease Indefinite
 Due to Generalized arteriosclerosis "
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other _____
 Address Catonsville 28 Md. Date signed 1/18/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 468

00234

1. PLACE OF DEATH:

County Balto
 City or town Essey
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred
924 Benfrew St
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto
 City or town Essey
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 924 Benfrew
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Lucy Phillips

3. (b) Social Security Number

4. Sex F 5. Color or race Wh. 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Nov. 8th - 1871
 8. AGE: Years 76 Months 2 Days 23 If less than one day
 hrs. min.

9. Birthplace Vinton, Va.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business At Home
 12. Name John Gray
 13. Birthplace Va.
 14. Maiden name Bessie M. George
 15. Birthplace Va.

16. Informant Sylvia Irene Henderson
 Address 924 Benfrew St
 17. Funeral home Date thereof 1-31-48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Mountain View C
 Location Vinton, Va
 18. Funeral director John G. Connolly
 Address 418 Eastern Ave
 19. 1-31-48 19
 (Date rec'd by registrar) Registrar John G. Connolly

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31 19 48 at 8:50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19 to 19
 and that I last saw h. alive on 19

Immediate cause of death Carcinoma of Liver
Diabetes Mellitus

Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide
 Date of
 Where did injury occur? Home
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE M. B. O'Connell M.D.
Alph. med. Exam. Balto Co. Md.
 Address Dundalk, Md. Date signed 1/31/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Registered No. 00235

Maryland State Dept. of CERTIFICATE OF DEATH

1. PLACE OF DEATH: Health (a) Baltimore City, Maryland 320 Sollers Pt. Turner Station (b) Street address (c) Hospital or institution: (d) Length of stay in hospital or inst. (yrs., mos., or days) (e) Length of stay in Baltimore (yrs., mos., or days)			2. USUAL RESIDENCE OF DECEASED: (a) State Md. (b) County Baltimore (c) City or town Turners Station (If outside city or town limits, write RURAL and give town) (d) Street No. 320 Sollers Point Road. (If rural give location) (e) Citizen of foreign country? (Yes or No) If yes, name country		
3 (a) FULL NAME SALLIE BELLE PHILLIPS					
3 (b) If veteran, name war			3 (c) Social Security Account No.		
4. Sex Female		5. Color or race Colored		6 (a) Single, married, widowed, or divorced. Married	
6 (b) Name of husband or wife Dedret Phillips					
6 (c) If alive, give age years					
7. Birth date of deceased (mo., day, yr.) May 4, 1922					
8. AGE: Years 25		Months		Days	
If less than one day hr. min.					
9. Birthplace S. Carolina (Town, county, and state)					
10. Usual Occupation Housewife					
11. Industry or business					
MOTHER					
12. Name Cabb Kelley					
13. Birthplace S. C.					
14. Maiden Name Elizabeth Miles					
15. Birthplace S. C.					
16 (a) Informant Dedret Phillips					
(b) Address 320 Sollers Point Road					
17 (a) Removal (b) Date thereof Jan 16/48 (Burial, cremation, or removal) (month) (day) (year)					
(c) Cemetery or crematory					
Location Chester S. Carolina					
18 (a) Funeral director Mrs. E. A. Ellis, Jr.					
(b) Address 1129 D. East Hill St., N.E.					
19 (a) JAN 17 1948 (b) New, Belvoir (Date rec'd by Registrar) ams Registrar					
MEDICAL CERTIFICATION					
20. DATE OF DEATH Jan. 14, 1948, at 11.15 M					
21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> and that the causes of death were:					
IMMEDIATE CAUSE OF DEATH Coronary thrombosis					
Due to					
Other Conditions					
(Include pregnancy within 3 months of death)					
22. If an external cause was primary <input type="checkbox"/> or contributing <input type="checkbox"/> cause of death, fill in the following:					
(a) Date of injury at M.					
(b) Where did injury occur?					
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?					
(d) Means of injury					
23. Signature George A. Merrill M.D. Medical Examiner.					
Date signed 1-15-48					

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00236

1. PLACE OF DEATH:

County BaltimoreCity or town Back River
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town _____
(If outside city or town limits, write RURAL and give nearest town)Street No. 440 Oriole Avenue
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Vaclav J. Pospisil

3. (b) Social Security Number

4. Sex male 5. Color or race white 8. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Mary T. (nee Priol)7. Birth date of deceased (mo., day, yr.) Sept. 28, 1878 6. (c) If alive, give age _____ years8. AGE: Years 69 Months 3 Days 11 If less than one day _____ hrs. _____ min.9. Birthplace Czechoslovakia
(Town, county, and state)10. Usual occupation retired

11. Industry or business

12. Name Anton Pospisil13. Birthplace Czechoslovakia14. Maiden name MARY KUTILEK15. Birthplace Czechoslovakia16. Informant Mrs. Mary T. Pospisil - wifeAddress 440 Oriole Avenue, BALTO. 24. MD.17. Burial Burial Date thereof 1/23/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or place Holy RedeemerLocation 4430 Belair Road, Baltimore, Md.18. Funeral director Charles E. SchimunekAddress 2601-3-5 E. Madison Street19. 1/27/48 X-8 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 19 48 at 5³⁰ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 16 19 47 to Jan 19 19 48and that I last saw him alive on Jan 19 19 48

Immediate cause of death _____ DURATION _____

Arteriosclerotic C.V. Disease 2-16-47Acute coronary thrombosis 1-19-48Due to Acute coronary occlusion

Due to _____

Due to _____

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide 2 Date of _____Where did injury occur? Ind (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. Schimunek M.D. M. D. or other _____Address 842 S. East Ave Date signed 1-21-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. X2

1. PLACE OF DEATH:

County BaltimoreCity or town Halters
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? —Hospital, institution, or street address where death occurred: —How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Halters
(If outside city or town limits, write RURAL and give nearest town)Street No. 1957 Belle Ave. - Oak Brook
(If rural, give LOCATION)2.(a) If veteran, name war —

3. (a) FULL NAME

Maria E. Rauschenberg

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Carl H.7. Birth date of deceased (mo., day, yr.) June 9-1867 6. (c) If alive, give age 81 years8. AGE: Years 80 Months 6 Days 15 If less than one day — hrs. — min.9. Birthplace Germany
(Town, county, and state)10. Usual occupation Housewife11. Industry or business at Home12. Name George Menzies13. Birthplace Germany14. Maiden name unknown15. Birthplace Germany16. Informant Dr. Carl H. RauschenbergAddress 1957 Belle Ave. - Halters17. Cause Chorea Date thereof 7-July 48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory But OlivetLocation Baltimore18. Funeral director St. Elizabeth's HospAddress 1300 Euteria Place19. 1/5 48 A.W. Hedrick
(Date rec'd by registrar) (year) (month) (day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3, 1948 at 1:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 48 to 1/3 19 48and that I last saw him alive on 1/3 19 48Immediate cause of death arteria sclerotic DURATION 6 months
but diseaseDue to —Due to —Other conditions chronic occlusion 1 day

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE Benjamin Miller MD M. D. or otherAddress 2030 Wilkens Ave Date signed 1/5/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

00238

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
How long in hospital or institution? 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town (17)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2313 Druid Hill Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war WW-I

3. (a) FULL NAME

JOHN REDD

3. (b) Social Security Number

220-03-4252

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) 4-13-1887 6. (c) If alive, give age years

8. AGE: Years 60 Months 8 Days 27 If less than one day hrs. min.

9. Birthplace Bethesda, Maryland
(Town, county, and state)

10. Usual occupation Amn. Handler

11. Industry or business

FATHER 12. Name Frank Redd
13. Birthplace Virginia

MOTHER 14. Maiden name Malinda
15. Birthplace Virginia

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial Date thereof 1-13-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Baltimore National
Location Baltimore, Maryland

18. Funeral director William A. Jackson
Address 916 Penna. Ave. Bldg 1.

19. Jan 13 19 48 A. D. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10, 19 48 at 7:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 29, 19 47 to January 10, 19 48
and that I last saw him alive on January 10, 19 48

Immediate cause of death
Pulmonary Heart Disease with
cardiac Failure
Due to (1) Pulmonary Emphysema
(2) Bronchial Asthma

DURATION

3 Yrs.
2 weeks
3 Yrs.
3 Yrs.

Other conditions
(Include pregnancy within 8 months of death)

Major findings of operations
Date of op.
Autopsy results none performed
PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A.C. Newnam
A.C. NEWNAM, M. D. M. D. or other
Address V.A.H. FORT HOWARD, MD. Date signed 1-10-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH.

County Balto
 City or town Bella
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltoCity or town Bella
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Carl M. Reidenbaugh

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Harry Reidenbaugh7. Birth date of deceased (mo., day, yr.) Aug 31, 19008. AGE: Years 47 Months 4 Days 14 If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation at home

11. Industry or business _____

12. Name Sommerfield Green13. Birthplace md.14. Maiden name Catherine Snyder15. Birthplace md.16. Informant Harry ReidenbaughAddress Bella md.17. Burial Date thereof 1-18-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory OaklandLocation Oakland Mills md.18. Funeral director J.P. Sig. in bothAddress Ellicott City md.19. 1-17 1948 V.E. Harvey
(Date rec'd by registrar) (year) (signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1948 at 1 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 13 1948 to January 15 1948 and that I last saw him alive on 13 January 1948Immediate cause of death Respiratory Failure

DURATION

Due to Myasthenia Gravis 5 years

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE William F. TassawayAddress Ellicott City, Md. M. or other _____Date signed 15 Jan 48

RECEIVED
JAN 19 1948
BUREAU 12

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00240

 93d
 30
 Reg. Dist. No.

1. PLACE OF DEATH:
 County Baltimore
 City or town Catonsville 28, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr. 5 mons. 10 das.
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 1 yr. 5 mons. 10 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Baltimore, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4812 Park Heights
 (If rural, give LOCATION)
 2.(a) If veteran, name war. ✓

3. (a) FULL NAME

Jennie L. Restivo

3. (b) Social Security Number

4. Sex Female
 5. Color or race W
 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Joseph Restivo
 6. (c) If alive, give age 69 years
 7. Birth date of deceased (mo., day, yr.) January 17, 1889
 8. AGE: Years 58 Months 11 Days 22 It less than one day hrs. min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Domestic
 12. Name Salvatore Liberto
 13. Birthplace Italy
 14. Maiden name Rose Baranco
 15. Birthplace Italy

16. Informant Hospital Records
 Address Catonsville 28, Maryland
 17. Burial Date thereof 1/12/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cathedral
 Location Baltimore City
 18. Funeral director B. Verna Lerner
 Address 4611 Park Heights
1-9-48 A. W. Hedrich L
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1948 at 6:45 p. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29, 1946 to January 8, 1948
 and that I last saw her alive on January 8, 1948

Immediate cause of death
Subarachnoid hemorrhage DURATION 2 days
Bilateral broncho pneumonia 5 days
 Due to Arteriosclerotic heart disease indefinite
Coronary sclerosis "
 Other conditions Picks' disease? "

(Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Isadora York, M.D. M. D. or other
Catonsville 28, Md. Date signed 1/9/48
 Address

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Singewald
1613 E. North Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00241

Reg. Dist. No. 44

1. PLACE OF DEATH:

County RosedaleCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1223 Sixty-Second Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County RosedaleCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1223 Sixty-Second Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John S. Reusing

3. (b) Social Security Number

212-07-1062

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Carrie

7. Birth date of

deceased (mo., day, yr.)

March 23, 1895

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

52930

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Machinist

11. Industry or business

FATHER

12. Name

John Reusing

13. Birthplace

Germany

MOTHER

14. Maiden name

Agatha Kirchgessner

15. Birthplace

Germany

16. Informant

Mrs. Carrie Reusing

Address

1223 Sixty-Second St.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

1-26-48

(month) (day) (year)

Cemetery or crematory

Holy Redeemer

Location

Baltimore

18. Funeral director

Leonard J. Ruck

Address

5305 Harford Road, 14

19.

(Date rec'd by registrar)

January 26, 1948C. W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22nd, 1948, at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 10, 1947, to Jan. 22, 1948and that I last saw him alive on January 21, 1948

Immediate cause of death

Carcinoma of the Pancreas & Stomach

DURATION

6 Mos.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 1613 E. North Ave. Date signed 1-23-48

Evidence for
change of cause of
death shown on
Film G437, 11/21/51. LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00242

CERTIFICATE OF DEATH

Reg. Dist. No. 39

1. PLACE OF DEATH:

County... Baltimore
City or town... Phoenix (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 51 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Baltimore
City or town... Phoenix (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Caper Mill Rd.
(If rural, give LOCATION)
2. (a) If veteran, name war... WW

3. (a) FULL NAME

Joseph Rieder

3. (b) Social Security Number

None

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Carrie E. (Nehrer)
8. (c) If alive, give age... year
7. Birth date of deceased (mo., day, yr.) Mar. 12, 1869

8. AGE: Year 78 Months 9 Days 26 If less than one day... hrs. ... min.

9. Birthplace Germany -
(Town, county, and state)

10. Usual occupation Fanner

11. Industry or business

FATHER 12. Name August Rieder
13. Birthplace Germany

MOTHER 14. Maiden name Barbara Coleman
15. Birthplace Germany

16. Informant Mrs. Jos. Rieder
Address Phoenix Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Jan. 9, 1948
(month) (day) (year)
Cemetery or crematory Chesnut Grove
Location Sweet Air Balto. Co. Md.

18. Funeral director Landrum W. Brooks
Address Sparks, Md.

19. Jan. 8, 1948 Anna Price
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 19 48 at 1:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 19 47 to Jan 7 19 48
and that I last saw him alive on Dec 29 19 47

Immediate cause of death PNEUMIA, PULMONARY FAILURE, ARTERIO-SCLEROSIS, ANEMIA DURATION 10 yrs.

Due to ARTERIO-SCLEROSIS OVER 10 yrs.

Due to

Other conditions Minimal tuberculosis, asthma, chronic bronchitis, emphysema
(Include pregnancy within 3 months of death)

Major findings of operations... Date of op.

Autopsy results...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work?

23. SIGNATURE John A. Rutscher M. D. or other
Address 126 Caper St. Date signed Jan 7/48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 10 1948

SECRET

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00243

1. PLACE OF DEATH: County <u>Baltimore</u> City or town <u>Lutherville, Md.</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>4 yrs</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County City or town <u>Lutherville</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Greenspring Ave</u> (If rural, give LOCATION) 2(a) If veteran, name war			
3. (a) FULL NAME <u>Miss Margaret Robertson</u>				3. (b) Social Security Number			
4. Sex <u>F.</u>		5. Color or race <u>W.</u>		6. (a) Single, married, widowed, or divorced <u>Single</u>			
6. (b) Name of husband or wife							
7. Birth date of deceased (mo., day, yr.) <u>July 8, 1864</u>							
8. AGE: Years <u>83</u> Months Days If less than one day hrs. min.							
9. Birthplace <u>Scotland</u> (Town, county, and state)							
10. Usual occupation <u>None</u>							
11. Industry or business <u>"</u>							
FATHER		12. Name <u>William Robertson</u>					
MOTHER		13. Birthplace <u>Scotland</u>					
14. Maiden name <u>Margaret Russell</u>		15. Birthplace <u>Scotland</u>					
16. Informant <u>Mrs. Roland Parker</u> Address <u>Greenspring Ave Lutherville Md.</u> <u>Cremation</u>							
17. (Burial, cremation, or removal, which?) Date thereof <u>1/8/48</u> (month) (day) (year) Cemetery or crematory <u>Landon Park</u> Location <u>Baltimore, Md.</u>							
18. Funeral director <u>Loring Byers</u> Address <u>5005 Park Heights Ave</u>							
19. (Date rec'd by registrar) <u>1/8/48</u> <u>A. W. Hedrick</u> Registrar							
MEDICAL CERTIFICATION							
20. DATE OF DEATH <u>January 7th</u> 19 <u>48</u> at <u>7</u> A.M.							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Dec 15</u> 19 <u>45</u> to <u>Jan 5</u> 19 <u>48</u> and that I last saw him alive on <u>Jan 5</u> 19 <u>48</u>							
Immediate cause of death <u>Senile degeneration</u>							
Due to <u>Arterio Sclerosis</u>							
Due to							
Other conditions							
(Include pregnancy within 3 months of death)							
Major findings of operations							
Date of op.							
Autopsy results							
PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following:							
Accident, suicide, or homicide. Date of							
Where did injury occur? (City or town) (County) (State)							
Injured at home, farm, industry, public place (where?)							
Means of injury Injured at work?							
23. SIGNATURE <u>James H. Green</u> M. D. or other Address <u>5611 Pinebrook</u> Date signed <u>1-8-48</u>							

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47d

0024442

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

County Baltimore
City or town Baltimore Highlands
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
4306 Baltimore St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State MD County Highlands
City or town Baltimore Highlands
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4306 Baltimore St
(If rural, give LOCATION)
2. (a) If veteran, name war 10

3. (a) FULL NAME

Joseph E Robinson

3. (b) Social Security Number

218-18-9523

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Florence E Robinson

7. Birth date of deceased (mo., day, yr.) April 2, 1896 6. (c) If alive, give age 52 years

8. AGE: Years 57 Months 9 Days 8 If less than one day hrs min.

9. Birthplace Baltimore MD
(Town, county, and state)

10. Usual occupation Chorister

11. Industry or business

12. Name Joseph E Robinson

13. Birthplace Cambodge ST

14. Maiden name Carrie Moore

15. Birthplace Baltimore MD

16. Informant Florence E Robinson

Address 4306 Baltimore St Baltimore

7. Burial (Burial, cremation, or removal, which?) Date thereof 1/13/48 (month) (day) (year)

Cemetery or crematory Baltimore

Location Baltimore

18. Funeral director Thomas G. Lee

Address 1217 1st Ave SE

19. Jan 12 1948 Date rec'd by registrar

C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1948, at 10 M

I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to Jan 10 1948 and that I last saw him alive on Jan 9, 1948

Immediate cause of death Carcinoma of lung DURATION 6 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
Physician Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Schufeldt M. D. or other

Address Mo. Amundson Date signed 1/12/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltoCity or town Inverness
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

131 Bayside Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltoCity or town Inverness
(If outside city or town limits, write RURAL and give nearest town)Street No. 131 Bayside Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Clara Ross

3. (b) Social Security Number

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Frank E.6. (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.)

Aug. 9th 1890

8. AGE:

Years 57Months 4

Days

If less than one day

hrs. min.

9. Birthplace

Minnesota
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

at home

FATHER

12. Name

Frank Schultzy

13. Birthplace

Miner.

MOTHER

14. Maiden name

Clark

15. Birthplace

"

16. Informant

Mr. Frank E. Ross

Address

131 Bayside Drive

17. (Burial, cremation, or removal. Which?)

Date thereof

Jun - 7 - 48
(month) (day) (year)

Cemetery or crematory

Woodlawn Ceme.

Location

Woodlawn, Md.

18. Funeral director

John B. Connolly

Address

418 Eastern Ave.

19.

1-7-48

19

(Date rec'd by registrar)

John B. Connolly

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 4th 19 48 at 11:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 19 47 to Jan. 19 48and that I last saw her alive on Jan. 3 19 48

Immediate cause of death

Cancer of Cervix

DURATION

5 yrs2) Cervical Metastases toto cervix, bladder -18 mrs.

Due to

Vesico-VaginalFistula5 mrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

home

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. B. Davis

M. D. or other

Address

Date signed

1/5/48

RECEIVED
JAN 7 1948
BUREAU F.B.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County Baltimore CountyCity or town Kensington
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Balts. CountyCity or town Kensington
(If outside city or town limits, write RURAL and give nearest town)Street No. 730 Warwick Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Joseph Salvatore

3. (b) Social Security Number

217-05-0464

4. Sex

Male

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Natalie

7. Birth date of deceased (mo., day, yr.)

Unknown

6.(c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

6977

hrs.

min.

9. Birthplace

Romania
(Town, county, and state)

10. Usual occupation

Stone mason

11. Industry or business

FATHER

12. Name

?

13. Birthplace

?

MOTHER

14. Maiden name

?

15. Birthplace

?

16. Informant

John Salvatore

Address

730 Warwick Rd

17.

Burial
(Burial, cremation, or removal, Which?)Date thereof Jan 20 - 48
(month) (day) (year)

Cemetery or crematory

London Park Cem

Location

Greenleaf Rd

18. Funeral director

Joseph Kasinski Inc

Address

606 Washington Blvd

19.

Jan 20 48
(Date rec'd by registrar)

19.

Chas Koffler

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 19 48 at 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 3 19 47 to Jan 17 19 48and that I last saw him alive on Jan 15 19 48

Immediate cause of death

Coronary Occlusion

DURATION

1 hr.

Due to

Coronary Artery Disease2 yr.

Due to

Arteriosclerosis3 yr.

Other conditions

Phlebitis (leg)

(Include pregnancy within 8 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Chas Koffler

M. D. or other

Address

1938 W. Balto. StDate signed 1/19/48

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

REPORT OF DEATH

RECORDED

JAN 27 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 93d 00247

1. PLACE OF DEATH:

County BaltimoreCity or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 mos

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md CountyCity or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)Street No. 7733 Fairgreen Rd.
(If rural give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JOHN MAGNUS SANDBERG

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Late Louise

7. Birth date of deceased (mo., day, yr.)

May 26, 1954

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

93725

hrs.

min.

9. Birthplace

Sweden

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

- Sandberg

13. Birthplace

Sweden

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

MRS. HELEN ZOLLARS

Address

7733 Fairgreen Rd - Dundalk Md

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Jan. 23, 1948
(month) (day) (year)

Cemetery or crematory

Location

Washington, Pa.

18. Funeral director

Henry H. Witke

Address

4101 Edmondson Ave

19.

1/21/48
(Date rec'd by registrar)A. W. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21, 1948 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 161947to Jan 21, 1948

and that I last saw him alive on

1948

Immediate cause of death

Cerebral Thrombosis

DURATION

8 hrs.

Due to

Hypertension with vacuolar disease

Due to

Generalized arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Eugene F. Nevey M.D.

D. or other

Address

7501 Myrmidon Rd. Dundalk, Md.

Date signed

1-21-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 38

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6575-Maplewood Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 31, 1896

8. AGE: Years 71 Months 0 Days 28 If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Thomas Schunkel

13. Birthplace Md.

14. Maiden Name Sarah Ruston

15. Birthplace Md.

16 (a) Informant Mrs. Edna Jacob

(b) Address 6575-Maplewood Rd.

17 (a) Burial Date thereof 2/2/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Frederick Rd.

18 (a) Funeral director John F. Henry, Inc.

(b) Address 245- Light St.

19 (a) FEB 2 1948 (Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County Balt

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No 6575-Maplewood Rd (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29, 1948, at 4³⁰ P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1945 to 1/29/48, and that I last saw h. alive on 1/29/48.

Immediate cause of death

Myocardial Failure

Duration

3 months

Due to Hypertensive Cardio

Vascular Renal

Due to Disease

10 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Chas. F. Donnell

Address 7301 York Rd Date signed 1/31/48

M. D.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00249

Reg. Dist. No.

1. PLACE OF DEATH:

County.....Baltimore
City or town.....Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....50 days
Hospital, institution, or street address where death occurred:
Veterans Administration Hospital
How long in hospital or institution?.....50 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State.....Maryland County.....
City or town.....Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.....38 S. Hanover Street
(If rural, give LOCATION)
2. (a) If veteran, name war.....WW

3. (a) FULL NAME

ERNEST SCHNEIDWIND

3. (b) Social Security Number

Unknown

4. Sex.....Male 5. Color or race.....White 6. (a) Single, married, widowed, or divorced.....Divorced
6. (b) Name of husband or wife.....
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.).....January 1, 1889
8. AGE: Years.....59 Months.....0 Days.....13 If less than one day..... hrs. min.

9. Birthplace.....Brooklyn, New York
(Town, county, and state)
10. Usual occupation.....Retired
11. Industry or business.....
12. Name.....Albert Schneidwind
13. Birthplace.....Germany
14. Maiden name.....Augusta Meyer
15. Birthplace.....Germany

16. Informant.....Clinical Records, Veterans Adminis-
Address.....tration, Fort Howard, Maryland

17. Burial..... Date thereof.....1/17/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory.....Baltimore National Cemetery
Location.....Baltimore, Maryland
Howard H. Blight Jr.
18. Funeral director.....Blight Funeral Home
Address.....4914 Belair Rd., Balto., Md.

19. 1/16 - 48 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....January 14.....1948 at.....11:30 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 25.....1947 to.....January 14.....1948
and that I last saw him alive on.....January 14.....1948

Immediate cause of death.....
ENDOCARDITIS, MITRAL VALVE,
ETIOLOGY UNKNOWN

DURATION

Unknown

Due to.....
Due to.....
Other conditions.....ATROPHY OF BRAIN
LOBULAR PNEUMONIA
(Include pregnancy within 3 months of death)

Unknown

2 days

Major findings of operations..... Date of op.

Autopsy results.....Substantiated above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?.....

23. SIGNATURE.....Dr. McKernan M.D.
Address.....Depty. Medical Examiner
Balto. Co. - Dundalk Md. 4/15/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

00250

1. PLACE OF DEATH: *Baltimore*
 County *Baltimore*
 City or town *Pikesville*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *2 yrs.*
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? *May 10, 46*

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State *MD* County *Baltimore*
 City or town *Pikesville*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *Campfield Rd*
 (If rural, give LOCATION)
 2.(d) If veteran, name war

3. (a) FULL NAME *Louis R. Schultz*

3. (b) Social Security Number

4. Sex *M* 5. Color or race *W.* 6. (a) Single, married, widowed, or divorced *Single*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *July 25, 1884* 8. (c) If alive, give age years

8. AGE: *63* Years Months *7* Days *6* If less than one day hrs. min.

9. Birthplace *Baltimore, Md*
 (Town, county, and state)

10. Usual occupation *Killed*

11. Industry or business *John P. Schultz*

12. Name *Germany*

13. Birthplace *Germany*

14. Maiden name *Julia*

15. Birthplace *Germany*

16. Informant *Records*

Address *Wingbury Ave*

17. (Burial, cremation, or removal, which?) *Burial* Date thereof *Feb 3, 48* (month) (day) (year)

Cemetery or crematorium *Immanuel*

Location *Green Lane*

18. Funeral director *L. HEE MANN & SON*

Address *6067 Hartford Rd*

19. *2/2* 19. *48* *L.W. Redick* Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Jan 31* 19 *48* at *4 P.* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *June - 13* 19 *47* to *Jan - 31* 19 *48* and that I last saw him alive on *Jan - 30* 19 *48*.

Immediate cause of death *1) carcinoma of esophagus* DURATION *1 yr.?*

Due to

Due to

Due to

Other conditions *- hypertension*

Heart disease (Include pregnancy within 8 months of death) *5 yrs.*

Major findings of operations *- Primary malignancy of esophagus* Date of op. *Nov 1947*

Autopsy results *done*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE *Earl L. Chambers M.D.* M. D. or other

Address *4108 Liberty Ave* Date signed *2/2/48*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

00251

1. PLACE OF DEATH

County BaltimoreVillage or City White House

No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.2. FULL NAME Minnie Cordelia Seakes(a) Residence: No. White House

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widowed</u>
--------------------	------------------------------	---

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE ofJohn Franklin Seakes6. DATE OF BIRTH (month, day, and year) Nov. 5 - 1876

7. AGE <u>72</u>	Years	Months <u>2</u>	Days <u>5</u>	If LESS than 1 day, hrs. or min.
---------------------	-------	--------------------	------------------	--

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Home care

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) 1948 - Jan. 10.11. Total time (years) spent in this occupation 45 yrs.12. BIRTHPLACE (city or town) Balts. Co. Md.
(State or country)13. NAME Thomas Watson Merryman14. BIRTHPLACE (city or town) Balts. Co. Md.
(State or country)15. MAIDEN NAME Ruth E. Mallonee16. BIRTHPLACE (city or town) Md.
(State or country)17. INFORMANT Susan Seakes
(Address) Upperco, Md.18. BURIAL, CREMATION, OR REMOVAL
Place Grace M.E. Date Jan. 13, 194819. UNDERTAKER Edward C. Lipton
(Address) Hampstead, Md.20. FILED Cyril E. Fowble, Md.
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

January 10, 1948
(Month) (Day) (Year)22. I HEREBY CERTIFY, That I attended deceased from
Jan. 10, 1948, to Jan. 10, 1948I last saw her alive on Jan. 10 - 2:30 P.M., 1948; death is said to have occurred on the date stated above, at 2:50 P.M.The PRINCIPAL CAUSE OF DEATH and related causes of Importance were as follows: Cerebral Hemorrhage -
Hemiplegia - with paralysis
left side

Date of onset

Sudden

Other Contributory Causes of Importance:

Arterio-sclerosis with
hypertension 220several
years.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of Injury _____, 19____

Where did Injury occur? _____

(Specify city or town, county and State)
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Cyril E. Fowble
(Address) Upperco, Md.

M. D.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis

Date of onset

1915

Chronic interstitial nephritis

1921

Cerebral hemorrhage

July 5, 1927

Other contributory causes of importance:

Gallstones

May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy

Date of onset

1 week ago

Run over by street car

1 week ago

Peritonitis

3 days ago

Other contributory causes of importance:

Gastroenteritis

1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00252

Reg. Dist. No. 35

1. PLACE OF DEATH:

County... BALTIMORE

City or town... CATONSVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... BALTIMORE

City or town... CATONSVILLE
(If outside city or town limits, write RURAL and give nearest town)Street No. 2114 ROCKWELL AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

GEORGE V. SEYLER

3. (b) Social Security Number

212-10-9903

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife... MARY E. SEYLER

7. Birth date of deceased (mo., day, yr.) JANUARY 7 th. 1872

8. AGE: Years 76 Months --- Days 11 If less than one day

9. Birthplace... VIRGINIA
(Town, county, and state)

10. Usual occupation... CIGAR MANUFACTURER

11. Industry or business... OWNER OF BUSINESS

12. Name... CARL SEYLER

13. Birthplace... GERMANY

14. Maiden name... MARIE KOHLMAN

15. Birthplace... GERMANY

16. Informant... MRS. MARY E. SEYLER -wife

Address... 2114 ROCKWELL AVE. CATONS.

17. BURIAL Date thereof JAN. "21/48"

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... LOUDON PARK CEMETERY

Location... BALTIMORE MARYLAND

18. Funeral director... F.B. WIPPERT & SON

Address... 1300 EUTAW PLACE... 17.

19. 1/20 88 A.W. Medical Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 18th. 1948 at 10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 12 1948 to Jan 18 1948

and that I last saw him alive on Jan 18 1948

Immediate cause of death

DURATION

General Phlebotomy

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE J. A. K. H. W. M. D. or other

Address... Date signed 1/20/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1240

pc 00253

Reg. Dist. No.

44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. Wentworth Apts., Mulberry & Cathedral Sts.
(If rural, give LOCATION)2.(a) If veteran, name war WW ✓

3. (a) FULL NAME

ORLANDO C. SHELLEY

3. (b) Social Security Number

None

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

6. (b) Name of ~~husband~~ wife Olivia L. Shelley7. Birth date of deceased (mo., day, yr.) 10/8/96

8. AGE:	Years	Months	Days	It less than one day
	<u>51</u>	<u>3</u>	<u>19</u>	hrs. min.

9. Birthplace Altoona, Pa.
(Town, county, and state)10. Usual occupation Candy business

11. Industry or business

12. Name Jeremiah Shelley13. Birthplace Pennsylvania14. Maiden name Susan K. Frederick15. Birthplace Pennsylvania16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Buried Wentworth Apts. Date thereof 1/29/48
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory WentworthLocation Wentworth18. Funeral director William Cook Funeral MansionAddress St. Paul & Preston Sts. Balto. Md.19. 1/28/48 A. W. Bedard
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 19 48 at 7:55 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 20 19 48 to January 27 19 48and that I last saw him alive on January 27 19 48

Immediate cause of death

LAENNEC'S CIRRHOSISDURATION
1 yr.
plus

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. MANAUGH M. D. or otherAddress VAH, Ft. Howard, Md. Date signed 1/28/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00254

37

1. PLACE OF DEATH:

County BaltimoreCity or town Lutherville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

Seminary Avenue

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Lutherville
(If outside city or town limits, write RURAL and give nearest town)Street No. Seminary Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Rebecca Virginia Shock

3. (b) Social Security Number

4. Sex Female5. Color or race White6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife George Henry Shock

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 5, 18618. AGE: Year 86 Months 8 Days 20 It less than one day _____ hrs. _____ min.9. Birthplace Chestnut Ridge Balto. Co., Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business At Home12. Name Unknown13. Birthplace "14. Maiden name Unknown15. Birthplace "16. Informant Mrs. Elmer RufenachtAddress Lutherville, Md.17. Burial Date thereof Jan. 27, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sater's Baptist Cem.Location Lutherville Balto. Co., Md.18. Funeral director John Burris SonsAddress Towson, Maryland19. Jan. 27, 1948 Messner C Ensey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25, 1948 at 7:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 19, 1947 to Jan 25, 1948and that I last saw her alive on Jan 24, 1948

Immediate cause of death _____

DURATION

Broncho-Pneumonia, Term. 4 daysDue to Hemiplegia, Rt 12 yrsDue to Hypertension Uchi

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations noneAutopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Bennett A. Stoen M. D. or other _____Address Lutherville Date signed 1/25/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 3 1948

RUSSIA

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00255

1. PLACE OF DEATH: **Baltimore**
County.....
City or town.....**Woodlawn**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....**55 yrs**
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....**Md.**..... County.....**Baltimore**
City or town.....**Woodlawn**
(If outside city or town limits, write RURAL and give nearest town)
Street No.....**5810 Windsor Mill Road**
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME
Mary Elizabeth Smith

3.(b) Social Security Number
none

4. Sex Female	5. Color or race White	6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife..... Daniel E. Smith		
6.(c) If alive, give age..... years		
7. Birth date of deceased (mo., day, yr.) Jan. 15, 1874		
8. AGE: 73	Years 11	Months 29
Days hrs. min.		

9. Birthplace.....**Washington, D. C.**
(Town, county, and state)
10. Usual occupation.....**At Home**

11. Industry or business.....

FATHER
12. Name.....**Joseph Rittler**
13. Birthplace.....**Not Known**

MOTHER
14. Maiden name.....**Iglehart**
15. Birthplace.....**Germany**

16. Informant.....**Theodore Smith**
Address.....**5810 Windsor Mill Rd.**

17. **Burial** Date thereof.....**Jan. 16, 1948**
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....**Lorraine Park**
Location.....**Woodlawn, Md.**

18. Funeral director.....**J. Howard Strong**
Address.....**3207 W. North Ave.**

19. **1/15** 19**48** **G.W. Hedrick**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH.....**January 13, 1948** at **12:30** P.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Dec 1** 19**47** to **Jan 13** 19**48**
and that I last saw her alive on **Jan 13** 19**48**

Immediate cause of death.....**myocarditis**
DURATION
about 2 mo.

Due to.....**advanced atherosclerosis**
Due to.....
Other conditions.....**Hypertension**
(Include pregnancy within 8 months of death)

Major findings of operations.....
Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?

23. SIGNATURE.....**Charles D. Smith**
Address.....**2220 Garrison Blvd**
Date signed.....**Jan 15/48**

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00256

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County Balto.City or town Catonville
(If outside city or town limits, write RURAL and give nearest town)Street No. 712 Meadowbrook Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

John Douglas Snearinger

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

June 28, 1947

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

627

hrs.

min.

9. Birthplace

Balto. Ind.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Michael C. Snearinger

13. Birthplace

Ind.

MOTHER

14. Maiden name

Michaela Snearinger

15. Birthplace

Ind.

16. Informant

Address

Mrs. Michaela Snearinger712 Meadowbrook Ave.

17.

(Burial, cremation, or removal. Which?)

Date thereof

1-27-48
(month) (day) (year)

Cemetery or crematory

Bonewaga Cem.

Location

Adams Co. Penna.

18. Funeral director

Address

George A. FisherCatonville Ind.

19.

(Date rec'd by registrar)

1-241948

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 19 48 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Birth

19

to

Jan 2419 48

and that I last saw him alive on

Jan 2519 48

Immediate cause of death

Pneumonia, Bronchial

DURATION

1 day

Due to

Mental DeficiencyBirth

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

NONE

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm M. Seabold

M. D. or other

Address

5402 EdmonsonDate signed 1-24-48

RECORDED
JAN 27 1948
FBI - NEW YORK

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH:

County Balt.
 City or town Middlebrook
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

3. Transverse Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltCity or town Middlebrook
 (If outside city or town limits, write RURAL and give nearest town)Street No. 3 Transverse Ave
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

FLOSSIE S. SPENCER

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

F

W

W

6. (b) Name of husband or wife Lloyd A. Spencer

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July-15-18878. AGE: Years Months Days If less than one day
 60 5 21 hrs. min.9. Birthplace Nicholson Township
 (Town, county, and state)10. Usual occupation Housewife11. Industry or business Ret. Housewife12. Name Jack Spencer13. Birthplace Black14. Maiden name William, Jack15. Birthplace Black16. Informant Mrs. F. Chas. SpencerAddress 3 Transverse Ave17. Removal Date thereof 1-6-47
 (Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Nicholson AveLocation Nicholson Ave18. Funeral director John G. ConnollyAddress 518 Eastern Ave19. 1-6-47 19. John G. Connolly
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 19 48 at 4:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 19 19 47 to January 6 19 48and that I last saw her alive on January 5 19 48Immediate cause of death infarction

DURATION

4 wksDue to corary thrombosisDue to Hypertensive arteriosclerosis
heart disease

Other conditions

(Include pregnancy within 8 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

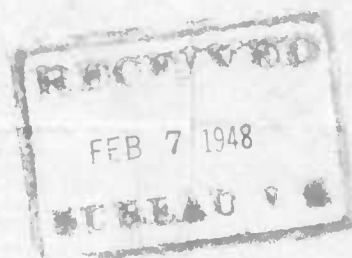
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Jack Wesler, M.D.Address 805 Swilley Ave, Balt 20 M. D. or other
 Date signed 1/6/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

00258

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County BaltimoreCity or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3

Hospital, institution, or street address where death occurred:

21 Sherwood AveHow long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balto.City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)Street No. 21 Sherwood Ave

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME

Hedwig Theresa Springmann

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

M

6.(b) Name of husband or wife

George W Springmann

7. Birth date of

1 August8.(c) If alive, give age 66 years

deceased (mo., day, yr.)

CHW
Aug 1, 1886

8. AGE:

61 Years7 Months3 Days

If less than one day

— hrs. — min.

9. Birthplace

Baltimore, Md

(Town, county, and state)

10. Usual occupation

H. W

11. Industry or business

12. Name

Lundheim Jurin

13. Birthplace

Germany

14. Maiden name

?

15. Birthplace

16. Informant

George W. SpringmannAddress 21 Sherwood Ave. Pikesville, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan 7 - 48

(month) (day) (year)

Cemetery or crematory

Finkelsburg

Location

Carroll Co

18. Funeral director

J. F. Ellis Sons

Address

Prestonsburg Md

19. 1 - 5 -

(Date rec'd by registrar)

19. 48

Dr E E Nichols

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 January 4 19. 48 at 1:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4 July19. 47to 3 Jan.19. 48

and that I last saw her

alive on3 Jan.19. 48

Immediate cause of death

rightCarcinoma of breast

DURATION

Due to —Due to —

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of —

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) —

Means of Injury

Injured at work? —

23. SIGNATURE

Charles H. Williams M.D.

M. D. or other

Address Pikesville 8, Md.Date signed 4 Jan 48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 7 1948

SECRET

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County... Baltimore
 City or town... Brighton - Baltimore 15
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Balto Co. 25 yrs.
 Hospital, institution, or street address where death occurred:
6518 Mt. Vernon Ave.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Baltimore Co.
 City or town... Brighton - Baltimore 15
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 6518 Mt. Vernon Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

GRACE SPRINKLE

3. (b) Social Security Number

4. Sex Female	5. Color or race White	6.(a) Single, married, widowed, or divorced Widowed
------------------	---------------------------	--

6.(b) Name of husband or wife... George Sprinkle
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) August 30, 1873
 8. AGE:

Years 74	Months 4	Days 11	If less than one day hrs. min.
-------------	-------------	------------	--

9. Birthplace... Carroll County nr. Westminster
 (Town, county, and state)
 10. Usual occupation... Housewife
Own Home

11. Industry or business

12. Name... Milton Ward
 13. Birthplace... Carroll County, Md.
 14. Maiden name... Frances Martin
 15. Birthplace... Carroll County, Md.

16. Informant... Mrs. King Marley
 Address... 6518 Mt. Vernon Ave
 17. Burial Date thereof 1-14-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Woodlawn Cemetery
 Location... Woodlawn Md

16. Funeral director... Loring Byers
 Address... 5005 Park Heights Ave.
1 - 12 - 48
 19. (Date rec'd by registrar) 19..... E. E. Michael Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... January 11th 1948 at 4:25 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 19 43 to Jan. 11, 19 48
 and that I last saw her alive on January 11, 19 48

Immediate cause of death	DURATION
<u>Coronary Thrombosis</u>	<u>Sudden</u>
Due to... <u>Chronic Myocarditis</u>	
Due to... <u>Arterio Sclerosis</u>	
Other conditions... <u>Senility</u>	
(Include pregnancy within 3 months of death)	

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?
 23. SIGNATURE E. E. Michael
 M. D. or other
 Address... Pikesville-8, Md. Date signed 1/12/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00260

Reg. Dist. No. 31

1. PLACE OF DEATH:

County BaltimoreCity or town Hollesfield
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltoCity or town Gwynn Oak Sta Balto 7, Md
(If outside city or town limits, write RURAL and give nearest town)Street No. Wagon Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Archie E Stauffer

3. (b) Social Security Number

4. Sex

m

5. Color or race

w

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Ella Wilt Stauffer

7. Birth date of deceased (mo., day, yr.)

Mar 25, 1881

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

66921hrs.min.

9. Birthplace

md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

James Stauffer

13. Birthplace

Pa

MOTHER

14. Maiden name

Annie Braummer

15. Birthplace

md.

16. Informant

Mrs Ella W Stauffer

Address

Gwynn Oak Sta Balto 7, Md

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

1-18-48
(month) (day) (year)

Cemetery or crematory

Good Shepherd

Location

Ellenist City, md.

18. Funeral director

J.C. Dy. in botham

Address

Ellenist City, md.

19.

1/12/48
(Date rec'd by registrar)

19.48

Tom E. Martin
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1948, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 1947 to Jan. 16 1948and that I last saw him alive on Jan. 15 1948

Immediate cause of death

Cardio Vascular Disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Pandallstown Date signed 1/12/48

RECEIVED
FEB 2 1948
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

00261

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 47 years 5 months 22 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 47 years 5 months 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Arlington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Daisey Steffey

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 1900 1880
 8. AGE: Years 67 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Unknown - Maryland
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business None
 12. Name Unknown
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant Hospital records
 Address Catonsville, 28, Md.
 17. Burial Date thereof 1/19/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematorium Lorraine Cemetery
 Location Baltimore Md.
 18. Funeral director Spring Bros.
 Address 5025 PA Highway
 19. Jan. 17, 1948
 (Date rec'd by registrar) Registrar W.E. Harris

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16, 1948 19____ at 2:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25, 1900 19____ to January 16, 1948 19____
 and that I last saw him alive on January 16, 1948 19____

Immediate cause of death Right lower lobe bronchopneumonia DURATION 24 hours

Due to Cerebral embolus 1 week

Due to Hypertensive C.V. disease Indefinite

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury _____ Injured at work? _____

23. SIGNATURE Isadore Turk, M.D.

M.D. or other _____

Address Catonsville, 28, Md. Date signed 1/16/48

RECEIVED
JAN 19 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

195d

00262

44

Reg. Dist. No.

1. PLACE OF DEATH

County Balto.

City or town Middle River
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

4 N. Randolph St
all life.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town Leesdale
(If outside city or town limits, write RURAL and give nearest town)

Street No. Victory Villa Garden
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Joseph Michael Stegman.

3. (b) Social Security Number

4. Sex

male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Dec 19/1947.

8. AGE:

Years

Months

Days

(If less than one day)

6 weeks

9. Birthplace

Baltimore Md
(Town, county, and state)

10. Usual occupation

none.

11. Industry or business

FATHER

12. Name

Chas. E. McGrath

FATHER

13. Birthplace

Oklahoma

MOTHER

14. Maiden name

Mary Jane Stegman

MOTHER

15. Birthplace

Pratt, Kansas

16. Informant

Mrs. Rita O'Donnell

Address

above

17.

(Burial, cremation, or removal, Which?)

Date thereof

2-3-48
(month) (day) (year)

Cemetery or crematory

Texas Ams House

Location

Texas, Md

18. Funeral director

John B Connelly

Address

418 E Eastern Ave.

19.

(Date rec'd by registrar)

2-3-48
John B Connelly
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1948 at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death

Diffraction
from dehiscence of Ventrals.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

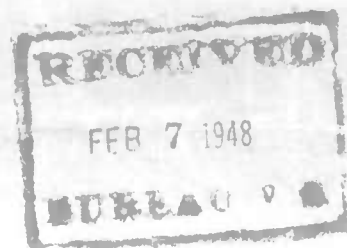
23. SIGNATURE McNamee, M.D.
Deputy Medical Examiner
Address Balto. Co. Denton St. Date signed 1/31/48

MARGIN RESERVED FOR BINDING

I

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If the correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County... Baltimore Co.

City or town... Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred:

Opitz Home

How long in hospital or institution? 10 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Balto

City or town... Luthersville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

James H. Stewart

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.) unknown 8 58

8. AGE:

Years

Months

Days

If less than one day

hrs. m/n.

9. Birthplace

York Co. Penn.

(Town, county, and state)

10. Usual occupation

machinist

11. Industry or business

FATHER

12. Name

Thomas R. Stewart

13. Birthplace

unknown

MOTHER

14. Maiden name

Sarah Jane Bay

15. Birthplace

unknown

16. Informant

Address

Opitz Home, Records
Catonsville, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

1 31 48

18. Cemetery or crematory

Address

Spartan, Md
12101 Brooks

19. Registrar

Date rec'd by registrar

1 30 48 VE Harry

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1948 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1937 to Jan 30 1948 and that I last saw him alive on Jan 30 1948

Immediate cause of death

Chr Myocarditis

DURATION

14Y

Due to

Chr Pericarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

1-30

Handwritten notes, possibly "Page 10" and "for the record".

Handwritten notes, possibly "B. J. ..."

Handwritten notes, possibly "James H. ..."

Handwritten notes, possibly "8-8 ..."

RECEIVED
FEB 2 1948
FBI - NEW YORK

Handwritten notes, possibly "B. J. ..."

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1948

1878

70

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00264

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Randallstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 69 years
 Hospital, institution, or street address where death occurred:
Dorsey Avenue
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... md. County..... Balt.
 City or town..... Randallstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Dorsey Ave.
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

William Henry Sudman

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

none

7. Birth date of

deceased (mo., day, yr.)

April 20, 1878

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

69816

..... hrs. min.

9. Birthplace

Randallstown
(Town, county, and state)

10. Usual occupation

farmer

11. Industry or business

farmer

FATHER

12. Name

John D. Sudman

13. Birthplace

Beth Baltimore, Md.

MOTHER

14. Maiden name

Louise W. Leuge

15. Birthplace

Rockville, Md.

16. Informant

Ms. Emma Hagenrath sister

Address

McDonough Rd, Randallstown

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

Jan. 8 1948
(month) (day) (year)

Cemetery or crematory

St. Mary's Cemetery

Location

Randallstown, Md.

18. Funeral director

Address

St. Mary's Langston
4510 Liberty Heights Ave.

19. (Date rec'd by registrar)

Jan 7 48H. W. Hedrich
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 5 January..... 19. 48..... at..... 7:50..... A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2 Jan..... 19. 48..... to..... 5 Jan..... 19. 48and that I last saw him alive on..... 4 January..... 19. 48

Immediate cause of death

Cerebral hemorrhage

DURATION

Due to..... Hypertensive C.V.D.

Due to

Other conditions..... left hemiplegia

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles F. Williams M.D.

M. D. or other

Address..... Pikesville 8, Md...... Date signed..... 5 Jan. 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00265-38

1. PLACE OF DEATH:

County BaltimoreCity or town Towson 4, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 8 mo 14 days

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, MarylandHow long in hospital or institution? 1 yr 8 mo 14 days

3. (a) FULL NAME

Dorothy Sullivan

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

James W Sullivan

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Dec 21 1914

8. AGE:

Years

Months

Days

If less than one day

33309

hrs.

min.

9. Birthplace

Harre de Grace

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER

12. Name

Andrew Jackson

13. Birthplace

Perryville Md

14. Maiden name

Edna Rouse

15. Birthplace

Harre de Grace Md

Personal history - Hospital Records

16. Informant

Address Eudowood Sanatorium, Towson 4, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Jan 3 - 1948

Cemetery or crematory

Angel Hill

Location

Harre de Grace Md

18. Funeral director

Address Harre de Grace Md

19. Jan. 2

(Date rec'd by registrar)

19 48

G. H. Lewis M. D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty Harford 6

City or town

Harre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 1 1948at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 19 1946to Jan 1 1948

and that I last saw him alive on

Dec 31 1947

Immediate cause of death

Pulmonary TBC

DURATION

2 1/2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. A. Bridges

M. D. of other

Address

Towson 4, MarylandDate signed Jan. 1 - 48

RECORDED
JAN 6 1948
FBI - NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH: Baltimore
 County.....
 City or town..... Fullerton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 3 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland..... County..... Baltimore
 City or town..... Fullerton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Camp Chapel Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

BERTIE SWEETMON

3. (b) Social Security Number

4. Sex..... female
 5. Color or race..... white
 6.(a) Single, married, widowed, or divorced..... married
 6.(b) Name of husband or wife..... William C. Sweetmon
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... Dec. 4th, 1884
 8. AGE: Years..... 63 Months..... Days..... 26
 If less than one day..... hrs. min.

9. Birthplace..... Pa.
 (Town, county, and state)
 10. Usual occupation..... at home
 11. Industry or business.....
 12. Name..... Henry Cline
 13. Birthplace..... Pa.
 14. Maiden name..... Brenneman
 15. Birthplace..... Pa.

16. Informant..... Mr. William C. Sweetmon
 Address..... Camp Chapel Rd., Fullerton, Md.
 17. burial
 (Burial, cremation, or removal. Which?) Date thereof..... 1/5/48
 (month) (day) (year)
 Cemetery or crematory..... Woodlawn
 Location..... Baltimore, Md.
 18. Funeral director..... Leach Funeral Home
 Address..... 7401 Belair Road
 19. 1/3/48
 (Date rec'd by registrar) Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan. 1st, 19..... 48, at 9:45 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 5 19..... 47, to JAN. 1 19..... 48
 and that I last saw her alive on DEC. 31 19..... 47

Immediate cause of death..... acute Cardiac Dilatation
 DURATION..... 15 min.
 Due to..... Chronic Myocarditis..... 1 yr.
 Due to.....
 Other condition.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town)..... (County)..... (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... Lloyd E. Taylor M.D.
 M. D. or other.....
 Address..... 3902 Greenmount Ave. Date signed..... 2 JAN. 1948

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 8 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Spanish Point
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md CountyCity or town Baltimore 24
(if outside city or town limits, write RURAL and give nearest town)Street No. 3601 E. Fayette St.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

4. Sex

M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

13

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

19.

A.W. Hedrick

Registrar

MEDICAL CERTIFICATION

DATE OF DEATH Jan 5th 1948 at 9:19 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

Coronary Occlusion

DURATION

1 hr

Due to

Due to

Other conditions

(include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M.D. Davis M.D.
Sps Med. Exam. Davis M.D.
Address Baltimore Date signed 1/5/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TASKER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County LorleyCity or town Bald County
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yls.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Julia Tasker

3. (b) Social Security Number

4. Sex

F

5. Color or race

C.

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Alexander

7. Birth date of deceased (mo., day, yr.)

Sept 30, 1897

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

70322

hrs.

min.

9. Birthplace

md
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

Charles Brown

13. Birthplace

md

14. Maiden name

Caroline Brown

15. Birthplace

md

16. Informant

Fannie Myers

Address

Lorley md

17. Burial (Burial, cremation, or removal. Which?)

Date thereof

Jan 25/48
(month) (day) (year)

Cemetery or crematory

Asbury Cemetery

Location

Lorley md

18. Funeral director

Mrs. G. H. Elliott & Son

Address

1129 N. Caroline St

19.

Jan. 24, 1948

Date rec'd by registrar

A. W. HedrickB Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

md

County

Baltimore

City or town

Lorley
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 22

19

48

at

9:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 21

19

48Jan 22

19

48and that I last saw him alive on Jan 22 1948

Immediate cause of death

Coronary occlusion

DURATION

2 days

Due to

hypertension (essential)Years?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Jed O. Hodous md

M. D. or other

Address

Edgwood, mdDate signed 1-22-48

36

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

00269

1. PLACE OF DEATH:

County Balto.
City or town Sparrows Pt.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Balto.
City or town Sparrows Pt.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 707 J. St.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

Daniel Taylor

3. (b) Social Security Number

217-01-0457

4. Sex male 5. Color or race col 6.(a) Single, married, widowed, or divorced Mr.
6.(b) Name of husband or wife Minnie Taylor
7. Birth date of deceased (mo., day, yr.) 1880 6.(c) If alive, give age _____ years
8. AGE: Years 67 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Cumtuck and Co. Va.
(Town, county, and state)

10. Usual occupation Lat. over

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden name Unknown
15. Birthplace

16. Informant Minnie Taylor
Address 707 J. St. Sparrows Pt.

17. (Burial, cremation, or removal, Which?) B. Date thereof 1-10-48
(month) (day) (year)

Cemetery or crematory Int. Calvary
Location P. A. Co.

18. Funeral director Samuel W. Sullivan, Jr.
Address 1011 N. Arlington Ave. Balto.

19. Jan. 6- 19 48 Dawson L. Harbor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 - 1948 at 3 P.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1945 to Jan 6 - 1948
and that I last saw him alive on Jan 4 - 1948
Immediate cause of death Cardiac Failure DURATION 3 days
Due to Chronic Hypertensive Cardio-
Vascular disease 3 yrs
Due to Generalized Arterio-
sclerosis Unknown
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations. Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dawson L. Harbor M.D.
Address Sparrows Point, Md. Date signed 1/6/48

MARGIN RESERVED FOR BINDING

VS 415 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 8 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00270

38

1. PLACE OF DEATH:

County... BaltimoreCity or town... Towson
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 1/2 yearsHospital, institution, or street address where death occurred:
405 W. Chesapeake Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... BaltimoreCity or town... Towson
(If outside city or town limits, write RURAL and give nearest town)Street No. 405 W. Chesapeake Avenue
(If rural, give LOCATION)2.(a) If veteran, name war... None

3. (a) FULL NAME

JOHN WESLEY THOMAS

3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Laura Bosley Thomas6. (c) If alive, give age 87 years7. Birth date of deceased (mo., day, yr.) January 22, 18568. AGE: Years 91 Months 10 Days 24 If less than one day
hrs. min.9. Birthplace Norfolk, Virginia
(Town, county, and state)10. Usual occupation Retired11. Industry or business Accountant- B. & O. R.R.12. Name Robert S. Thomas13. Birthplace North Carolina14. Maiden name Sarah Jessely15. Birthplace North Carolina16. Informant Mrs. Laura B. ThomasAddress 405 W. Chesa. Ave., Towson, Md.17. Burial Date thereof Jan. 19, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Wesley Chapel CemeteryLocation White Hall, Balto. Co., Maryland18. Funeral director John Burke's SonsAddress Towson, Maryland19. Jan 19 1948 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... January 16, 1948 at 10:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 1, 1947 to Jan 16, 1948and that I last saw him alive on Jan 16, 1948Immediate cause of death Heart disease, chronic DURATION 11/16/48with coronary occlusionDue to Arteriosclerosis and senile changes Unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Rollin B. Hudson M.D.Address Towson Md M. D. or otherDate signed 1/18/48

REC-774 210
JAN 24 1948
BUREAU 3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Baltimore
 City or town Owings Mills, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Now long in above place of death? Since April 28, 1939.
 Hospital, institution, or street address where death occurred:
Rosewood State Training School
 Now long in hospital or institution? Since April 28, 1939

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick
 City or town R.F.D.#1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Thompson, Hazel Marie

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced S
 6.(b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) August 13, 1929
 6.(c) If alive, give age _____ years

8. AGE: Years 18 Months 4 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D.C.
 (Town, county, and state)
 10. Usual occupation Inmate, Rosewood State Tr. School

11. Industry or business

MOTHER FATHER
 12. Name Thompson, Richard C.
 13. Birthplace Leesburg, Va.
 14. Maiden name Schranitz, Mary F.
 15. Birthplace St. Louis, Ill.

16. Informant Institutional Record Rosewood
 Address Owings Mills, Md. 23

17. Burial Date thereof 1-20-48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory St. Mary's Cemetery, Thurmont, Md.
 Location Thurmont, Md.

18. Funeral director Wm. M. Creager
 Address Thurmont, Md.

19. 1-20- 19 48 Mary B. Elime.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH January 19, 1948, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1948 to Jan. 19, 1948
 and that I last saw her alive on Jan. 19, 1948

Immediate cause of death Broncho Pneumonia
Acute Bronchitis

DURATION
5 Days
1 Wk.

Due to _____
 Due to _____

Other conditions Little's Disease with
symptomatic epilepsy.
 (Include pregnancy within 8 months of death)

Major findings of operations Microcephaly,
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

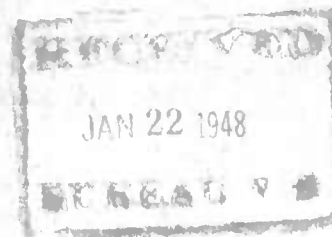
23. SIGNATURE Harry B. Bufler
 M. D. or other _____
 Address Owings Mills, Md. Date signed Jan 19, 1948

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In direct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00272 30

1. PLACE OF DEATH: BALTIMORE
 County.....
 City or town.....CATONSVILLE
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....4 MONTHS
 Hospital, institution, or street address where death occurred:
A. OPITZ HOME
 How long in hospital or institution?.....4 MONTHS

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....Maryland County.....Kent
 City or town.....Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....☒

3. (a) FULL NAME

Jacob F. Thompson

3. (b) Social Security Number

4. Sex.....male 5. Color or race.....white 6.(a) Single, married, widowed, or divorced.....widowed
 6.(b) Name of husband or wife.....Nettie M. Thompson
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.).....9 9 1867
 8. AGE: Years.....80 Months.....9 Days.....9 If less than one day..... hrs. min.

9. Birthplace.....MARYLAND
 (Town, county, and state)
 10. Usual occupation.....MERCHANT
 11. Industry or business.....RETIRED
 FATHER 12. Name.....UNKNOWN
 13. Birthplace.....
 MOTHER 14. Maiden name.....UNKNOWN
 15. Birthplace.....

16. Informant.....Rev. A. OPITZ HOME RECORD
 Address.....CATONSVILLE, Md.
 17.....Burial Date thereof.....Jan 17, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory.....Chester Cemetery
 Location.....Chestertown, Md.

18. Funeral director.....J. Willis Wells
 Address.....Chestertown, Md.

19.....1/15.....88.....A.W. Hedrick
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....June 15.....1948 at.....3 A.....M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....June 1.....1948 to.....June 15.....1948
 and that I last saw him.....alive on.....June 14.....1948

Immediate cause of death.....Chr. Myocarditis
 Due to.....General 325
arterio-sclerotic
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of Injury..... Injured at work?

23. SIGNATURE.....James H. Howard
 M. D. or other.....
 Address.....Catonsville Date signed.....1-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

00273

1108

1. PLACE OF DEATH:
County Baltimore
City or town Owings Mills, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 yrs. 4 mos. 21 days
Hospital, institution, or street address where death occurred:
Rosewood State Training School
How long in hospital or institution? 17 yrs. 4 mos. 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Owings Mills, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2(a) If veteran, name war _____

3. (a) FULL NAME

John Thompson

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) February 14, 1921 6. (c) If alive, give age _____ years

8. AGE: Years 26 Months 11 Days 2 It less than one day _____ hrs. _____ min.

9. Birthplace Prince George's County, Maryland
(Town, county, and state)

10. Usual occupation Inmate

11. Industry or business _____

12. Name Tommy Thompson

13. Birthplace ?

14. Maiden name Edna English

15. Birthplace ?

16. Informant Rosewood School records

Address Owings Mills, Maryland

17. Burial Date thereof Jan. 19-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rosewood

Location Belts Co.

18. Funeral director J. F. Eline, Sins

Address Prestonsburg Md.

19. 1-19-1948 Mary B. Eline
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 19 48 at 6:00 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 1 19 38 to Jan. 16 19 48
and that I last saw him alive on January 16 19 48

Immediate cause of death _____ DURATION

Broncho-pneumonia with pleurisy 5 days

Due to Bronchitis 2 days

Progressive muscular Dystrophy 17 yrs.

plus.

Other conditions ↓

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isabel H. McClinton

Isabel H. McClinton, M.D. M. D. or other

Address Rosewood, Owings Mills, Date signed 1/16/48

Maryland

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 20 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

00274

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
City or town near Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 months
Hospital, institution, or street address where death occurred: appts Home
How long in hospital or institution? 15 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Penn County Delaware
City or town Upper Darby
(If outside city or town limits, write RURAL and give nearest town)
Street No. The Blundell
(If rural, give LOCATION)
2.(a) If veteran, name war none ✓

3. (a) FULL NAME

Martha Nichols Tilghman

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife Single
7. Birth date of deceased (mo., day, yr.) March-3-1869
8. AGE: Years 78 Months 10 Days 3 If less than one day
hrs. min.

9. Birthplace Petersburg Va
(Town, county, and state)

10. Usual occupation Upper Darby

11. Industry or business

12. Name Tristram L. Tilghman

13. Birthplace Washington D.C.

14. Maiden name Anna Dade Bolling

15. Birthplace Petersburg Va

16. Informant Mrs Anna Bane Schotte (niece)

Address Amherst Mass

17. Cremial Date thereof 1-5-48
(Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory Rose Hill

Location Crematorium Md

18. Funeral director Shaw-Woodman Co

Address 108 W. Main Ave

19. 1/3 48 Q.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2nd 1948 at 2nd M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946 to Jan 2nd 1948
and that I last saw him alive on Dec 1/6 1947

Immediate cause of death Cerebral hemorrhage DURATION 24 hrs

Due to Cerebral Deterioration

Due to

Other conditions General Arterial Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

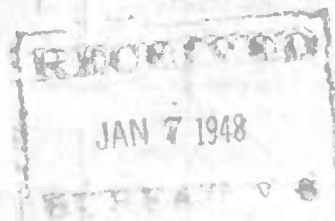
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Pearce M. D. or other

Address 2105 N. E. Park St Date signed Jan 4/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00275

Reg. Dist. No. 33

1. PLACE OF DEATH:

County BaltoCity or town Glyndon
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Butler Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Glyndon
(If outside city or town limits, write RURAL and give nearest town)Street No. Mantau Mill Rd., R.F.D.#1
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Elwood Tittle

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Jennie Tittle

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 19058. AGE: Years 42 Months _____ Days 9 If less than one day _____ hrs. _____ min.9. Birthplace Balto Co.
(Town, county, and state)10. Usual occupation Butler & Handy man

11. Industry or business

12. Name Oliver Tittle13. Birthplace Harford Co.14. Maiden name Carrie Gibson15. Birthplace Harford Co.16. Informant Raymond TittleAddress Glyndon, Md.17. Burial Date thereof Jan. 18, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetary or crematory Mt. JoyLocation Balto Co.18. Funeral director Charles M. BrooksAddress Sparks, Md19. Jan - 18 - 1948 Gary B. Eline
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 19 48 at 2:30A am21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-17-'48 19 48 to 1-17-'48 19 48
and that I last saw him alive on not seen alive 19 48Immediate cause of death Fracture Cervical Spine DURATION Instant

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

NONE Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 1-17-'48Where did injury occur? Near Glyn., Balto., Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Butler RoadMeans of injury Auto Accident Injured at work? No23. SIGNATURE D. D. D. Caples M.D. Exam
M. D. or otherAddress Reisterstown, Md. Date signed 1-17-48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 21 1948

SECRET, V 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00276

Reg. Dist. No. XX

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Maryland
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 909 W. Lombard St.
(If rural, give LOCATION)
2. (a) If veteran, name war WW-1 and WW-2

3. (a) FULL NAME
CHARLES L. TOUTLOFF, SR.
3. (b) Social Security Number
315-18-2069

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced
6. (b) Name of husband or wife Divorced
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) February 11, 1897

8. AGE: Years 50 Months 10 Days 20 If less than one day hrs. min.

9. Birthplace Ironwood, Michigan
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Frank Toutloff
13. Birthplace Canada

14. Maiden name May Winn
15. Birthplace Michigan

16. Informant Vets. Adm. Hosp. Clinical Records
Address Fort Howard, Maryland

17. Burial Burial Date thereof 1/5/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Location 5501 Frederick Ave. Balto. Md.

18. Funeral director Frank J. Cowan
Address 901 Hollins St. Balto. Md.

19. 1/5 XX A.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 19 48 at 10:05A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 30 19 47 to January 1 19 48
and that I last saw him alive on January 1 19 48

Immediate cause of death
Subarachnoid Hemorrhage due to
vascular disease with hypertension
DUE TO
DUE TO

Other conditions Hypertensive Cardiovascular
disease
(Include pregnancy within 3 months of death)
Major findings of operations no operations
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Paul O. Anderson
PAUL O. ANDERSON, M.D.
23. SIGNATURE Paul O. Anderson M. D. or other
Address VAH FT. Howard, Md. Date signed 1-1-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00277

Reg. Dist. No. 98

1. PLACE OF DEATH:

County Baltimore

City or town Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 mo 24

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? 10 mo 24

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harlt

City or town 2903 Poplar Terrace
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2903 Poplar Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME

Hamilton Tochudy
Eli Tochudy

3. (b) Social Security Number

215-03-1349

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Helen M. Tochudy

(nee Leach)

8.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) April 16, 1899

8. AGE: Years 48 Months 8 Days 17 If less than one day hrs. min.

9. Birthplace Meritt Pa
(Town, county, and state)

10. Usual occupation chef

11. Industry or business

12. Name Eli Tochudy

13. Birthplace Meritt Pa

14. Maiden name Sadie Turner

15. Birthplace Meritt Pa

Personal history - Hospital Records

16. Informant

Address Eudowood Sanatorium, Towson 4, Md.

17. Burial Date thereof 1/12/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Cathedral Cem.
Balto., Md.

Location WM. J. TICKNER & SONS

18. Funeral director Balto., Md.

Address

19. 1/12 19 48 R. W. Delush
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 19 48 at 11:50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15 19 47 to Jan 9 19 48

and that I last saw him alive on Jan 9 19 48

Immediate cause of death - Pulmonary TB

DURATION 2 1/2 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. W. Bridges M. D. or other

Address Towson 4, Maryland Date signed

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00278

Reg. Dist. No. 44

1. PLACE OF DEATH:

County... BaltimoreCity or town... Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?... Approximately 9 HoursHospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, MarylandHow long in hospital or institution?... Approximately 9 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County...City or town... Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2412 Guilford Ave
(If rural, give LOCATION)2.(a) If veteran, name war... WW-2

3. (a) FULL NAME

JOHN S. TULK

3. (b) Social Security Number

551-01-3925

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife... Irene Tulk7. Birth date of deceased (mo., day, yr.)... 3-25-148. (c) If alive, give age... 38 years

8. AGE: Years Months Days If less than one day

33926

hrs. min.

9. Birthplace... British Columbia Vancouver
(Town, county, and state)10. Usual occupation... Construction

11. Industry or business

12. Name... Norman A. Tulk13. Birthplace... Unknown14. Maiden name... Louisa MN Unknown15. Birthplace... Canada16. Informant... Clinical Records, Vets. Adm. HospitalAddress... Fort Howard, Md.17. Burial... 1/23/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Baltimore National CemeteryLocation... Baltimore, Maryland18. Funeral director... Blight Funeral HomeAddress... 4914 Belair Rd., Balto., Md.19. 1/22 19 48 DW Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... January 21, 1948 8:40 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 20, 1948 to January 21, 1948
and that I last saw him alive on January 21, 1948Immediate cause of death... SUBDURAL HEMATOMA, RIGHT, cause unknown.

DURATION

3 mos.

Due to...

Due to...

Other conditions... Fracture 10th Rib, right
Multiple Contusion of Body, cause unknown. (Include pregnancy within 8 months of death)

unknown

unknown

Major findings of operations...

Date of op...

Autopsy results... Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... [Signature] M. D. or otherAddress... Balto., Co. Date signed... 1/21/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully, he color of age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

00279

Reg. Dist. No. 20

1. PLACE OF DEATH:

County... Baltimore
 City or town... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 months, 26 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 4 months, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Maryland County...
 City or town... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 705 S. Montford St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war... - ✓

3. (a) FULL NAME

Mary Turowski

3. (b) Social Security Number

-

4. Sex <u>female</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>married</u>	
6. (b) Name of husband or wife... <u>Alexander Turowski</u>			
7. Birth date of deceased (mo., day, yr.) <u>April 22, 1890</u>			
6. (c) If alive, give age <u>56</u> years			
8. AGE:	Years	Months	Days
	<u>57</u>	<u>8</u>	<u>30</u>
If less than one day hrs. min.			
9. Birthplace... <u>Poland</u> (Town, county, and state)			
10. Usual occupation... <u>housewife</u>			
11. Industry or business... <u>home</u>			
FATHER	12. Name... <u>? Kilian</u>		
	13. Birthplace... <u>Poland</u>		
	14. Maiden name... <u>unk.</u>		
MOTHER	15. Birthplace... <u>Poland</u>		

16. Informant... hospital records
 Address... Catonsville 28, Md.

17. Burial... Jan 24/48
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
 Cemetery or crematorium... Sacred Heart of Mary
 Location... Baltimore

18. Funeral director... Fred W. Ogazowski
 Address... 730 Eastern Ave.

19. 1/22 19 48 A.W. Hedrich
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... January 21 19 48 at 6:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
August 26, 1947 19 48 to January 21 19 48
 and that I last saw h...er... alive on January 21 19 48

Immediate cause of death...
Chronic coronary heart disease. DURATION Indef.

Due to... Arteriosclerotic heart disease. Indef.

Due to... Generalized arteriosclerosis Indef.

Other conditions...
 (Include pregnancy within 3 months of death)

Major findings of operations...
 Date of op.

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
Isadore Tuerk, M.D.
Catonsville 28, Md. M. D. or other
 23. SIGNATURE...
 Address... Date signed 1/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 134 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, MarylandHow long in hospital or institution? 134 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 39 S. Kossuth Street

(If rural, give LOCATION)

2. (a) If veteran, name war WW-I

3. (a) FULL NAME

MARCELLUS H. UHLER

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Irma G. Uhler6. (c) If alive, give age 48 years

7. Birth date of

deceased (mo., day, yr.)

11-21-94

8. AGE:

Years

Months

Days

If less than one day

5329

hrs.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual occupation Electrician

11. Industry or business

MOTHER FATHER

12. Name Harry B. Uhler13. Birthplace Carroll Co. Maryland14. Maiden name Rapheal Ensey15. Birthplace Fairfax, Virginia16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 2/3/48

(month) (day) (year)

Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director WM. J. TICKNER & SONS, INC.Address North & Pa. Aves., Balto; Md.19. Feb 2 48

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(Date rec'd by registrar)

Registrar

3. (b) Social Security Number

813-079-317

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 19 48 at 7:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased

September 18 19 47 to January 30 19 48and that I last saw him alive on January 30 19 48

Immediate cause of death

Alveolar carcinoma, left upper lobe metastatic to brain

DURATION

6 Mos.plusDue to Unknown

Due to

Other conditions Lobular pneumonia, bilat3 days

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. C. MANAUGH, M. D.
Chief, Professional Service

M. D. or other

Address VAN, Ft. Howard, Md.Date signed 1-30-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55e

00281

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County 2606 Gehb Ave
Dorchester Heights Md.
 City or town (If outside city or town limits, write RURAL and give nearest town) 30 Yrs.

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore
 City or town Dorchester Heights
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2606 Gehb Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Rosie Vinci

3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife late Salvatore Vinci

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Feb. 5 1876

8. AGE: Years 71 Months 11 Days 8 If less than one day
 hrs. min.

9. Birthplace Cefalu * Palermo Italy
 (Town, county, and state)
House wife

10. Usual occupation..... home

11. Industry or business

12. Name Salvatore Gangelozzi
 13. Birthplace Italy

14. Maiden name Concetta Catanese
 15. Birthplace Italy

16. Informant Anna Glorioso (Daughter)
 Address 2606 Gehb Ave (Dorchester Heights Ave)

17. Burial Date thereof Jan. 16/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Cathedral
 Location Old Frederick Rd. Baltimore Md.

18. Funeral director Frauda Della Noce
 Address 52 N. Morley St.

19. 1/15 48
 (Date read by registrar) 19. 48

A.W. Hedrick
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 1948 19..... at 4.30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 12 1948 to Jan 12 1948
 and that I last saw him alive on Jan 12 1948

Immediate cause of death Emphysema

DURATION

months

Due to Generalized carcinoma 6 mo.
metastasis

Due to Carcinoma of arm 3 years
metastasis

Other conditions age

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Drumer M. D. or other

Address medial arts Bldg Date signed.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The corrected page is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00282 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 weeksHospital, institution, or street address where death occurred:
Opitz Old Age HomeHow long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 819 N. Streeper Street
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

JOSEPH VYSKOCIL

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of ~~husband~~ or wife Frances (nee Prochaska)7. Birth date of deceased (mo., day, yr.) November 4, 1865

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
82 2 23 hrs. min.9. Birthplace Czechoslovakia
(Town, county, and state)10. Usual occupation retired

11. Industry or business

12. Name Joseph Vyskocil
13. Birthplace Czechoslovakia14. Maiden name unknown
15. Birthplace II16. Informant Anton Vyskocil - son
Address 819 N. Streeper St.17. Burial Date thereof 1/30/1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy Redeemer
Location 4430 Belair Rod. Baltimore, Md.18. Funeral director Charles E. Schimunek
Address 2601-3-5 E. Madison Street19. 1/29/48 19 A. W. Hedrick
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 19 48 at 3.9 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 27 19 48 to January 27 19 48
and that I last saw him alive on January 26 19 48Immediate cause of death Uremia

DURATION

1 weekDue to Hypertension Cardio-Vascular
Renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William K. Gallagher M.D. M. D. or otherAddress Catonsville-28, Md. Date signed 1-28-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 31

1. PLACE OF DEATH:

County Baltimore
City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md. County Bolts
City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 299 Wood Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME

Ruth Walbarron

3. (b) Social Security Number

4. Sex F 5. Color or race C 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Charles
6.(c) If alive, give age 45 years
7. Birth date of deceased (mo., day, yr.) 11-13-1910
8. AGE: Years 37 Months 1 Days 24 It less than one day hrs. min.

9. Birthplace va.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
12. Name Chas. Simpson
13. Birthplace va.
14. Maiden name Chas. Thompson
15. Birthplace va.

16. Informant Chas. Walbarron (H)
Address Wood Rd - Woodlawn
17. Buried Date thereof 1-11-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Nazareth Cemetery
Location Boston, Va.
18. Funeral director Chas. H. Cooper
Address 510-12 N. Cambridge Ave.

19. 1/10 19 48 A.M. Hedrick
(Date rec'd by registrar) Registrar P.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7 48 at 7:35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 8 1947 to Jan 7 1948
and that I last saw he alive on Jan 7 1948

Immediate cause of death Acute coronary occlusion
DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dr. Franklin Chulpa M.D.
M. D. or other
Address 1543 Burma Ave Date signed 1/10/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00284

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Balto
City or town Janson RFD #6
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: L
How long in hospital or institution? L

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Balto
City or town Janson RFD
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Evelyn Thamer

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Dec 24, 1871

8. AGE: Years 76 Months 1 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace MD
(Town, county, and state)

10. Usual occupation Retired School

11. Industry or business at the day

12. Name Archibald Thamer

13. Birthplace MD

14. Maiden name Rebecca Thamer

15. Birthplace MD

16. Informant Therese Thamer

Address Harold Thamer

17. Burial Date thereof Jan 28, 48
(Burial, cremation, or removal, Whichever) (month) (day) (year)

Cemetery or crematorium St. Christopher

Location MD

18. Funeral director Charles E. Goss

Address Benson MD

19. Jan 28 19 48
(Date rec'd by registrar)

C. E. Cutler
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25, 1948 at 9:25 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/14 19 48 to 1/25 19 48

and that I last saw him alive on 1/24 19 48

Immediate cause of death _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Harold A. Gatt, M.D.

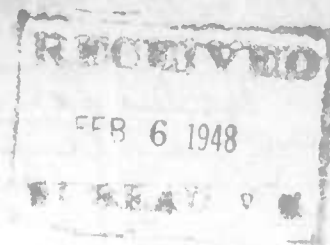
Address 8100 Harford Rd Date signed 1/26/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16
—
267



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00285

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Balto.
City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.
City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

Joseph Benjamin Washington

3.(b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced widowed
6.(b) Name of husband or wife Hattie Washington
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 16, 1895
8. AGE: Years 52-53 Months 8 Days 1 If less than one day hrs. min.

9. Birthplace Balto. Co.
(Town, county, and state)
10. Usual occupation laborer
11. Industry or business
12. Name William Washington
13. Birthplace Charles Co
14. Maiden name Matilda Diggs
15. Birthplace Balto C.

16. Informant Mrs. John Beard
Address Reisterstown, Md.
17. Burial Date thereof Jan. 21, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Piney Grove
Location Balto. Co.
18. Funeral director J.F. Eline, Sons
Address Reisterstown, Md.

19. 1-20- 19 48 Mary B. Eline
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-19- 48 at 10 P.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1- 1944 to 1-19- 48
and that I last saw him alive on 1-19- 48
Immediate cause of death myocarditis
decompensating DURATION 2 yrs
Due to
Due to
Other conditions chest acute abdomen 3 days
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE J. H. Saffell M. D. or other
Reisterstown Md Address Date signed 1-20-48

MARGIN RESERVED FOR BINDING

I

VS 415 9-45-15M

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

3-
R. H. H. V. R. D.

JAN 26 1948

ST. R. V. R. D.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 00286 38

1. PLACE OF DEATH:

County Baltimore
City or town Phoenix - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Rural-Phoenix -
(If outside city or town limits, write RURAL and give nearest town)
Street No. Blenheim Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Ruth Jenny Wells

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 1, 1946 6.(c) If alive, give age years

8. AGE: Years 1 Months 9 Days 20 It less than one day hrs. min.

9. Birthplace Baltimore City, Balt. Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Leroy Theodore Wells

13. Birthplace Royalton, Wisconsin

14. Maiden name Elizabeth Emma Steele

15. Birthplace Canton, Ohio

16. Informant Leroy Theodore Wells

Address Phoenix, Md

17. Burial Date thereof Jan 22 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Moreland Memorial Park

Location Baltimore Md

18. Funeral director Henry W. Jenkins & Sons

Address McCulloch & Orchard Sts

19. 1/21/48 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 January 1948 at 12:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 December 1947 to 20 January 1948 and that I last saw her alive on 16 January 1948

Immediate cause of death Retroperitoneal Sarcoma DURATION 7 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Retroperitoneal sarcoma Date of op. 20 July 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter T. Kees M.D. M. D. or other

Address Cockeysville, Md Date signed 1-20-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

00288

1. PLACE OF DEATH

County BaltimoreVillage or City Pleasant GroveRegistration Dist. No. 34 33

No. _____ St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 30 yrs. _____ mos. _____ ds. How long in U.S. if of foreign birth? _____ yrs. _____ mos. _____ ds.2. FULL NAME William B. Wendenburg(a) Residence: No. Pleasant Grove

St. _____ Ward _____

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
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5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Marie Amelia Wendenburg

6. DATE OF BIRTH (month, day, and year) Feb 19 - 1864

7. AGE Years <u>83</u>	Months <u>10</u>	Days <u>28</u>	If LESS than 1 day, _____ hrs. or _____ min.
------------------------------	---------------------	-------------------	--

OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Self-Chicken Business</u>
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.
	10. Data deceased last worked at this occupation (month and year) <u>Jan 1948</u>
	11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Germany
(State or country)13. NAME Unknown14. BIRTHPLACE (city or town) _____
(State or country)15. MAIDEN NAME Unknown16. BIRTHPLACE (city or town) _____
(State or country)17. INFORMANT wife - Marie Amelia Wendenburg
(Address) Bald Co. Md.18. BURIAL, CREMATION, OR REMOVAL
Place Pleasant Grove Date Jan 20, 194819. UNDERTAKER Edw C. Lepton
(Address) Hampstead, Md.20. FILED 1-18, 1948 Mary B E Line
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

January (Month) 17 (Day), 1948 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 14, 1948, to Jan 17, 1948
I last saw him alive on Jan 16, 1948; death is said to have occurred on the date stated above, at _____ P. M.

The PRINCIPAL CAUSE OF DEATH and related causes of Importance were as follows:

Cancer of stomach with regurgitation of food, pain, anorexia, etc.

Date of onset

2 yrs

Other Contributory Causes of Importance:

Myocardial degeneration with asthenia, arhythmia, Blood Pressure 140

Hypertension

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county and State)
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury _____

Nature of Injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) Cyril E. Finkle

M. D.

(Address) Upperco, Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>JAN 20 1948</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Evidence for change of cause
of death shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 114 JAN 19 1948 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 days
Hospital, institution, or street address where death occurred:
V.A.H. Fort Howard, Md.
How long in hospital or institution? 32 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2415 Washington Blvd.
(If rural, give LOCATION)
2. (a) If veteran, name war WW II

3. (a) FULL NAME

GEORGE WEYER, Jr.

3. (b) Social Security Number

Unknown 218-05-3085

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Mamie Weyer
7. Birth date of deceased (mo., day, yr.) October 16, 1898
8. AGE: Years 49 Months 2 Days 30 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

MOTHER FATHER
12. Name George Weyer
13. Birthplace Maryland
14. Maiden name Lillian Madison
15. Birthplace Maryland

18. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial Date thereof 1/19/48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery
Location Baltimore, Maryland

18. Funeral director Blight Funeral Home
Address 4914 Belair Rd., Balto. Md.

19. 1-16-48 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15, 1948 at 7:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 14, 1947 to January 15, 1948
and that I last saw him alive on January 15, 1948
Immediate cause of death HISTORY OF HYPERTENSION - 2 yrs. +
Hypertensive Cardiovascular disease 2 yrs.
CEREBRAL EDEMA 1 mo. +

Due to CARDIA HYPERTROPHY 12 yrs. +
NEPHRITIS-ARTERIOSCLEROTIC 2 yrs. +
Hypertensive 1 yr.

Other conditions CARDIA HYPERTROPHY
NEPHRITIS-ARTERIOSCLEROTIC
Hypertensive (include pregnancy & postnatal changes)
Major findings of operations Date of op.

Autopsy results Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Raymond Lipin
RAYMOND LIPIN M.D. M. D. or other
Address VAH, Fort Howard, Md. Date signed

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 00287

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Baltimore
 City or town Sundalk 22
 (If outside city or town limits, write RURAL and give nearest town)
 Street address, hospital, or institution:
239 Bitter Ct
 Length of mother's stay in County 4 mth
 (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
 County _____
 City or town Baltimore 25
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1308 Brinker Ct
 (If RURAL give LOCATION)

3. Name of child Mary White

5. Sex F

6. Twin or triplet No

4. Date of birth January 12, 1948 Hour 6:48 M.

7. No. of weeks pregnancy 20

FATHER OF CHILD

8. Full name Robert White
 9. Color ed 10. Age at time of this birth 25 yrs.
 11. Usual occupation Laborer

MOTHER OF CHILD

12. Full maiden name Janette Arnette
 13. Colored _____ 14. Age at time of this birth 21 yrs.
 15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1
 (b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor? _____ During labor? ✓

18. Pregnancy, complications of _____

19. Labor: (a) Complications of _____ (b) Induced? _____

20. (a) Was there an operation for delivery? NO
 (Yes or No)

(b) State all operations, if any _____

(c) Did child die before operation? _____
 During operation? _____

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes _____

(b) Maternal causes Trauma to Abdomen

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature William S. Stadel, M.D.
 (Specify if M. D., midwife, or other)

Address 140 Oak Ave.

23. (a) _____ (b) Date thereof _____
 (Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Cornegie Embryological

24. (a) Funeral director _____

(b) Address _____

25. (a) _____ (b) _____
 (Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)
 The above certificate has been examined by me.

Health Officer, per _____

* See Instruction C on stub.

Child born 5 minutes

V. S. A10

CNO.
COPY SENT TO LOCAL REGISTRAR No. DATE 1/15/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00290

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
Veterans Administration Hosp. Ft. Howard, Md.
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County _____
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 419 S. Bond Street
(If rural, give LOCATION)
2. (a) If veteran, name war VW I

3. (a) FULL NAME

EDWARD WORLEY

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife Single
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) July 8, 1896
8. AGE: Tears 50 Months 6 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Newport, Kentucky
(town, county, and state)
10. Usual occupation Cook
11. Industry or business _____
FATHER
12. Name Edward Worley
13. Birthplace Orleans, France
MOTHER
14. Maiden name Julia Mann
15. Birthplace New Orleans, La.

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland
17. Burial Date thereof 11/14/48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Baltimore, Maryland
Location Howard A. Blight, Jr.
18. Funeral director Howard A. Blight, Jr.
Address 4914 Belair Rd., Balto., Md.

19. 11/3/48 19 _____
(Date rec'd by registrar) Registrar A. W. Hedrick

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 19 48 at 6:25 P.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 8 19 48 to January 9 19 48
and that I last saw him alive on January 9 19 48
Immediate cause of death _____ DURATION
Pneumonia, right lower lobe 6 Days
Due to Pneumococcus 6 Days
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE V. Sciullo M. D. or other _____
Address V.A.H. FORT HOWARD, MD. Date signed 1-10-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully and legibly. is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00291

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years, 2 months, 17 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 2 years, 2 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince George
 City or town Berwyn
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ ✓

3. (a) FULL NAME

Edwin Yost

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) February 7, 1870
 8. AGE: Years 77 Months 11 Days 11 It less than one day _____ hrs. _____ min.

9. Birthplace District of Columbia
 (Town, county, and state)
Carpenter
 10. Usual occupation
 11. Industry or business Carpentering
 12. Name Robert Yost
 13. Birthplace Maryland
 14. Maiden name Elizabeth Ogden
 15. Birthplace District of Columbia

16. Informant Hospital records
Catonsville-28, Maryland
 Address
 17. Removal Date thereof 1-19-48
 (Burial, cremation, or removal - Which) (month) (day) (year)
Crematory Bladenburg, Md.
 Location
 18. Funeral director F. Wasch's Sons
Myattsville, Md.
 Address
 19. Jan. 19 1948 V.E. Harry
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 19 48 at 7:35 a. m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1 19 45 to January 18 19 48
 and that I last saw him alive on January 18 19 48
 Immediate cause of death _____
Coronary sclerosis DURATION indefinite
 Due to Arteriosclerotic heart disease "
Generalized arteriosclerosis "
 Due to Hypertensive cardiovascular
disease with decompensation 2 weeks
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
Isadore Tuerk, M.D.
 23. SIGNATURE _____ M. D. or other _____
 Address Catonsville-28, Md. Date signed 1-19-48

RECEIVED

JAN 20 1948

STEE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00292

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: Baltimore
 County.....
 City or town..... Catonsville (28) Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 days
 Hospital, institution, or street address where death occurred:
Harlem Lodge, Catonsville Md.
 How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Md. County..... WASH.
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 212 1/2 Vignetta Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ☒

3. (a) FULL NAME

NELLIE I. YOUNKINS.

3. (b) Social Security Number

4. Sex..... F
 5. Color or race..... W
 6.(a) Single, married, widowed, or divorced..... Married
 6.(b) Name of husband or wife..... FRANK W.
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... 8-2-06

8. AGE: Years..... 41 Months..... 5 Days..... 21
 If less than one day..... hrs. min.

9. Birthplace..... Hagerstown. Md.
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... Home

12. Name..... Elmer Kesseling

13. Birthplace..... Maryland

14. Maiden name..... Susan Rebecca Gumes

15. Birthplace..... Maryland

16. Informant..... Husband

Address..... Above

17. Burial, cremation, or removal. Which?..... Burial Date thereof..... 1/26/48
 (month) (day) (year)

Cemetery or crematory..... Rest Haven Cem.

Location..... Hagerstown Md.

18. Funeral director..... A.K. Coffman

Address..... Hagerstown Md.

19. 1-24 1948 V.E. Harze
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 1-23 1948 at 10 20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1-16 1948 to 1-23 1948
 and that I last saw h. er alive on 1-23 1948

Immediate cause of death..... Congestive heart failure
+ bronchopneumonia
 Due to..... Acute neurological
illness-type undiagnosed
 Due to..... possibly - brain abscess

DURATION

24 hrs

56 hrs

Other conditions..... Spinal fluid negative
 (Include pregnancy within 3 months of death)

Major findings of operations..... No

Date of op.....

Autopsy results..... Refused

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... A. Brooks Brown M.D.

Address..... Harlem Lodge (24) Md. M. D. or other

Date signed 1-24-48

RECEIVED

JAN 27 1968

RECEIVED